Sexuality and Sexual Health in Mental Health Care Settings: Perceptions of Psychologists, Psychiatrists, and Mental Health Nurses in Australia.

Kristi Lauren Urry

This thesis is submitted in fulfilment of the requirements for the degree of Doctor of Philosophy in the Faculty of Health and Medical Sciences, School of Psychology, at the University of Adelaide

September 2020

Table of Contents

List of publications in this thesis

Urry, K., & Chur-Hansen, A. (2018). Who decides when people can have sex? Mental health clinicians' perceptions of sexuality and autonomy. *Journal of Health Psychology*, 1359105318790026.

Urry, K., Chur-Hansen, A., & Khaw, C. (2019). 'It's just a peripheral issue': A qualitative analysis of mental health clinicians' accounts of (not) addressing sexuality in their work. *International Journal of Mental Health Nursing*, 28(6), 1278-1287. doi:10.1111/inm.12633

Under review

Urry, K. (Under review). Hidden but not silent: A reflexive account of (non)disclosure of sexual identity in qualitative research. *Qualitative Research*.

Abstract

Sexuality and sexual health needs are inadequately addressed in mental health settings. This is misaligned with the espoused recovery orientation underpinning mental health services in Australia, and with individuals' self-identified needs and desire for support. How mental health clinicians currently understand and respond to sexuality and sexual health concerns is still not well understood. In this thesis, I aimed to explore how mental health clinicians in Australia perceived sexuality and sexual health, and to critically examine how they oriented toward these in their work. An exploratory qualitative design was selected to address these aims, guided by social constructionist and critical health psychology frameworks. A single dataset was generated via in-depth interviews with psychologists, psychiatrists, and mental health nurses working in Australia. Four critical thematic analyses were conducted in relation to this dataset, each driven by a different analytic aim. In Chapter Three, I provide a reflexive account of nondisclosure of sexual identity within the research interviews as a lens through which to read the four analyses presented subsequently, contributing to transparency and rigour within this thesis.

Participants' conceptualisations of sexuality and sexual health are presented in Chapter Four. There was no single shared conceptualisation of sexual health within or across disciplines, however conceptualisations were primarily biomedical, reductionist, and risk-oriented with a focus on (primarily heterosexual) sexual intercourse. Sexuality was mostly understood as sexual identity and rarely discussed beyond reference to non-heterosexual identities, contributing to the positioning of hetero-sex as normal. Participants tended to perceive sexuality as relevant within their clinical practice when they also perceived danger or risk in relation to this, and this is explored in Chapter Five. I demonstrate how participants

drew on a neoliberal framework of (sexual) health and self-regulation to construct sexual danger, locating this within sexual expression itself or within distressed individuals who were perceived to lack self-regulation. Outside of perceived danger, sexuality was largely omitted from participants' everyday practice, and this silence is examined across two analyses. In Chapter Six, I demonstrate how participants accounted for omissions of sexuality in their own and their colleagues' everyday practice by deprioritising sexuality and locating it outside of mental health settings. In Chapter Seven, I examine how the institutional context in which participants learn and work shaped sexuality-related perception and practice, according to their own accounts. I argue that these workplaces and institutions produce and maintain a broader silencing and peripheralisation of sexuality within mental health settings.

The discussion in Chapter Eight brings together the results from all four analyses and synthesises these with the broader literature to make recommendations for practice and future research regarding sexuality and sexual health in mental health settings. I argue that improved practice in mental health settings will not be facilitated through a continued focus on biomedical aspects of sexuality and on individual clinicians' relevant knowledge, comfort, and competence. Rather, there is a need to broaden the approach to sexuality in both clinical practice and research, and to recognise the wider institutional contexts in which sexual and mental health care are conceptualised and delivered.

Declaration

I certify that this work contains no material which has been accepted for the award of any other degree or diploma in my name, in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. In addition, I certify that no part of this work will, in the future, be used in a submission in my name, for any other degree or diploma in any university or other tertiary institution without the prior approval of the University of Adelaide and where applicable, any partner institution responsible for the joint-award of this degree.

I acknowledge that copyright of published works contained within this thesis resides with the copyright holder(s) of those works.

I also give permission for the digital version of my thesis to be made available on the web, via the University's digital research repository, the Library Search and also through web search engines, unless permission has been granted by the University to restrict access for a period of time.

I acknowledge the support I have received for my research through the provision of an Australian Government Research Training Program Scholarship (fee-offset) and Faculty of Health and Medical Sciences Divisional Scholarship (stipend).

Kristi Lauren Urry

Signed: 07 September 2020

List of Presentations Based on This Thesis

Urry, K., Chur-Hansen, A., & Khaw. (July, 2019). "It's one of those societal taboo type things": A qualitative analysis of Australian mental health clinicians' accounts of (not) addressing sexuality in their work. Biennial conference of the *International Society of Critical Health Psychology*, Bratislava, Slovakia.

Urry, K., Chur-Hansen, C., & Khaw, C. (November, 2018). Sexual health matters: But it's more than just risk. *Eighth Service User Academia Symposium*, Melbourne, Australia.

Urry, K. (September, 2018). "Some clinicians have a very fixed idea of how people's sexual behaviour should be": Mental health settings as heteronormative space. Fifth Annual *Gender, Sex and Sexualities Postgraduate Conference*, Adelaide, Australia.

Urry, K., Khaw, C., & Chur-Hansen, A. (July, 2017). Who decides when people can have sex? Mental healthcare providers' perceptions of sexuality and autonomy. Biennial conference of the *International Society of Critical Health Psychology*, Loughborough, England.

Urry, K. (July, 2017). (Non)Disclosure of sexual identity in sexuality research: Reflexive account from a queer researcher. Biannual conference of the *Qualitative Methods in Psychology Section of the British Psychological Association*, Aberystwyth, England.

Urry, K., Khaw, C., & Chur-Hansen, A. (August, 2016). "It's more than just sex isn't it…": Sexual health in the mental health setting. [Poster presentation] The joint annual conference of the *European Health Psychology Society and British Psychological Society Division of Health Psychology*, Aberdeen, Scotland.

Urry, K. (16 October, 2016). Sexual health: Not a specialist area. [Invited talk] *South Australian College of Health Psychologists' Annual General Meeting and Continuing Professional Development on Sexual Health,* Adelaide, Australia.

Urry, K., Khaw, C., & Chur-Hansen, A. (December, 2016). Healthcare providers' understanding of sexual health in the mental health setting. [Poster presentation] *International Congress of Behavioral Medicine*, Melbourne, Australia.

Acknowledgements

This thesis is dedicated to my grandparents, Barbara and William Urry, who both passed away during this process and won't get to see me wear my funny hat. Nanna and Granddad never understood exactly what I was doing or why, but they believed in my perseverance to complete something big that I had decided to do – and they were so proud of me for that.

Of course, there are too many people to thank.

My partner, Yuan. I would not have been able to complete this PhD without your ongoing support. Thank you for helping me to stick it out, going with me when I changed my mind, and always trusting me to choose.

My supervisors, for supporting me to undertake this thing. Especially Anna, for taking me on despite my lack of qualitative research experience and patiently helping me to learn.

My past supervisors, Irina and Nick, who supported me in taking my first steps as a researcher and learning how to publish (and persevere through rejection). You were the first to suggest that I could do a PhD and, although I changed fields, the skills I learned through working with you both have been invaluable to all my research endeavours.

Britta, Ally, and Brett, who I first met at the 2017 QMiP and ISCHP conferences and who came to act as mentors through this winding process. Special thanks to Brett for joining my supervision panel late in the game.

The Fay Gale Alliance of Gender Scholars, who provided so many opportunities for growth, support, and collegiality.

The feminist PhD writing group and especially Shawna, for building such a beautiful, caring space to grow from and always return to.

Rosie, my dear office mate, and Matt, regular lunch companion, for your constant support. Between you, my research frustrations never went unheard, campus lunches were rarely lonely, and milestones were always acknowledged and celebrated appropriately.

Maddi, Kurt, Georgia, and Rico, for regular dinners and conversations that had *nothing* to do with research.

My family, for (mostly) understanding that this was work, not school.

Everyone else who asked about and listened to me describe my successes and frustrations, especially Esther, Olivier, Sarah, and Shoshannah. This was such a long process – people who have been instrumental in supporting me through the final months and years are not all the same ones who supported me in the beginning, or at some point along the way; and that's okay.

I pay absolutely no thanks to the neoliberal university environment that encourages and nourishes limitless perfectionism, productivity, and competition.

I acknowledge and pay respect to the Kaurna people, the traditional custodians of the Adelaide Plains where I live and work. Aboriginal sovereignty was never ceded.

Terminology and Abbreviations

Individual / Consumer / Service User

Much of the sexuality research that has been conducted within the context of mental health services has focussed on individuals who have 'serious' mental illness diagnoses (SMI: e.g., bipolar, schizophrenia, or psychotic disorders) or who are, or have been, inpatients in acute or forensic psychiatric settings (voluntarily or involuntarily). Individuals within these groups are often referred to as consumers (Australia, New Zealand, United States) or service users (Australia, United Kingdom), and many refer to themselves this way (Cromby, Harper, & Reavey, 2013; Deegan, 1999; Our Consumer Place, 2010). In this thesis, I primarily use the term 'individual' to refer to people experiencing mental distress, who have mental illness diagnoses, or who are accessing mental health services. This is for three main reasons: 1) Not everyone with those experiences described above self-identifies as a consumer/service user (see Scholz, Roper, Juntanamalaga, & Happell, 2019c); 2) I also discuss research in relation to people experiencing mental distress or accessing mental health services but who do not have SMI diagnoses and may not share the same social and economic experiences of those with these diagnoses; and 3) not all of the mental health clinicians who participated in the project worked with people who have SMI diagnoses or have stayed in inpatient settings.

Abbreviations That Appear Within This Thesis

ACMHN: Australian College of Mental Health Nurses

APS: Australian Psychological Society

DSM-5: Diagnostic and Statistical Manual of Mental Disorders, 5th edition

GP: General practitioner (medical doctor)

HIV: Human Immunodeficiency Virus

RANZCP: The Royal Australian and New Zealand College of Psychiatrists

SMI: Serious mental illness (Usually refers to mental illness diagnoses considered disabling and chronic, including schizophrenia, bipolar disorder, and psychosis)

STI: Sexually transmitted infection

WHO: World Health Organization

CHAPTER ONE: Introduction and Literature Review

"Those of us who have been diagnosed with major mental illness do not cease to be human beings by virtue of that diagnosis. Like all people we experience the need for love, companionship, solitude, and intimacy. Like all people we want to feel loved, valued, and desired by others." (Deegan, 1999, p. 21)

1.1 Introduction

Sexuality and sexual expression are important dimensions of life that contribute to peoples' wellbeing and sense of self. Sexuality, sexual expression, intimacy, and relationships remain an important part of life for many people experiencing mental distress or have a mental illness diagnosis, and who may be accessing mental health services (Davison & Huntington, 2010; Deegan, 1999; McCann, 2000, 2010; Volman & Landeen, 2007). Despite this, there is evidence that sexuality and sexual health needs continue to be under-addressed in mental health settings, both in Australia and internationally.

Despite an increasing acknowledgement of the relevance of sexuality and sexual health within the context of mental distress and mental health services, individuals' sexuality and sexual health needs remain inadequately addressed in mental health settings. Failing to adequately meet individuals' sexuality and sexual health needs can have a negative impact on their wellbeing and recovery (see McCann et al., 2019). Moreover, as I will argue in this thesis, this is not aligned with a recovery-oriented approach which now underpins mental health care provision in Australia (Australian Government, 2013a-c). Mental health care is not sufficiently holistic, person-centred, or recovery-oriented if sexuality and sexual health are not incorporated. It is therefore important that this issue is better understood and that mental health practice in relation to sexuality is improved.

In this thesis I take a social constructionist approach to sexuality and sexual health (explicated in sections 1.2.1., 2.2) within a critical health psychology framework (discussed in section 2.3) to explore how mental health clinicians understand and orient toward (or away from) sexuality and sexual health in their work. This is the overarching aim of the thesis. More broadly, the purpose of this thesis to contribute to wider efforts to ensure that the sexuality of individuals experiencing mental distress is recognised and that individuals' sexuality and sexual needs are more adequately met within mental health settings.

This is a *hybrid thesis*, so the forms of the chapters vary. The introduction and literature review, methodology, first major results chapter, and discussion are presented as traditional thesis chapters (Chapters One, Two, Four, and Eight). The remainder of the chapters presented are manuscripts that have been prepared for publication (Chapter Seven), submitted for publication (Chapter Three), or published in peer-reviewed academic journals (Chapters Five and Six: These are presented in their final accepted form, in a typeset consistent with the rest of the thesis). All references are presented in a single list at the end of the thesis.

In this chapter, I situate the concepts of sexuality and sexual health in their sociocultural and historical context and discuss the contested, polysemic nature of these concepts. I argue that, while there is no 'final' and discoverable definition of sexuality, different conceptualisations or definitions of these concepts function differently and are therefore useful and limiting across different contexts. I argue that, within the context of recovery-oriented mental health care, sexuality is best approached within clinical practice and research via an affirmative and holistic conceptualisation to that extends beyond bodies, biology, and risk. This approach is also best aligned with the perspectives and self-reported

needs of people experiencing mental distress and accessing mental health services. I then review the literature relevant to health and mental health clinicians' perceptions and practice in relation to sexuality and sexual health. Finally, I identify the current gaps in the literature that I aim to address through the research presented in this thesis and outline the research questions within this project, accordingly. The chapter closes with an overview of the thesis.

1.2 Sex, Sexuality, and (Sexual) Health

There are no universal definitions of sexuality or sexual health. Rather, sexuality, sexual identity, and sexual health are complex, socially constructed phenomena that cannot be understood in isolation from their broader historical, sociocultural, and political contexts (e.g., Foucault, 1980; Giami, 2002; Heath & White, 2002; Irwin, 1997; Weeks, 2010). The ways in which these concepts are defined have been, and are, contested and changing (Edwards & Coleman, 2004; Marks, Murray, Evans, & Willig, 2000; Weeks, 2010). Indeed, sexuality, sex, and sexual health have no fixed or concrete meaning. Rather, these have many meanings that change depending on the context, both across and within geographical, cultural, social, and temporal locations (Epstein & Mamo, 2017; Flowers, Hart, & Marriott, 1999; World Health Organization (WHO), 2010). The function or consequences of those different meanings also changes depending on the context. As I argue below, since different definitions or constructions of sexuality, sex, and sexual health function differently across various contexts, these are also useful and limiting depending on the context in which they are being invoked. It is therefore important to critically consider why a particular definition(s) is available or taken up within a specific context and what function it serves and for whom.

In this section, I outline a social constructionist approach to sex, sexuality, and the sexual body underpinning this thesis (social constructionism as a broad philosophical

framework within the thesis is discussed in section 2.2). I then discuss the concept(s) of sexual health (and sexuality), its proliferation, and the consequences of this for current approaches to sexuality and health. Finally, I outline the historical context within, or against, which sexuality is currently understood in Westernised[1] societies including Australia, both in the broad public imaginary and within the context of mental distress and mental health settings more specifically. In particular, I describe briefly how normative understandings of sex and sexuality have been shaped by medico-scientific and psychiatric knowledges and explore how sexuality has been approached within the context of mental distress and illness.

1.2.1. A critical, constructionist approach to sexuality.

This thesis is underpinned by a foundational notion that sexuality is an essential part of being human and that sexual expression and health can be usefully conceptualised as human rights. While these notions are currently widely accepted (within particular contexts) as 'true' and beneficial, they are not universal or final truths. This is because from a social constructionist perspective, as used in this thesis, sexuality is understood not as a natural or instinctual phenomenon that is driven by essential biological processes, but as a historically specific set of complex sociocultural practices (Marks et al., 2000; Weeks, 2010). This means that the way that sexuality, sex and sexual expression, and sexual health are understood within a particular time and place are a product of that specific cultural and historical context. The ways that sexuality and sexual health are understood, and the functions or actions made available by those meanings, also change across contexts within a society at a given time (e.g., Epstein & Mamo, 2017; Lupton, 2012). It is in this sense that sexuality is "an invention

[1] I use the term 'Westernised' societies to indicate the individualistic, capitalist, and (usually) Christian values and cultural assumptions that are dominant within and organise those societies (Fox, Prilleltensky, & Austin, 2009).

of the human mind" rather than a phenomenon independent of social processes (Weeks, 2010, p. 7).

The social construction of sexuality does not negate its "exist[ence] as a palpable social presence" (Weeks, 2010, p. 7). Sexuality, and other concepts attached or related to it, are highly important for the ways in which we organise and make meaning in relation to our everyday experiences and within institutions (Burr, 2015a; Rubin, 1984; Weeks, 2010), including within health and mental health care settings (Lupton, 2012). The meanings and practices surrounding (or, constituting) the concept of sexuality within Westernised societies are particularly moralised. This may be because our sexual lives play an important role in shaping and reproducing broader social and economic structures in terms of child bearing and caring, families, housing, and economic production (e.g., Burr, 2015a; Foucault, 1980; Rubin, 1984; Weeks, 2010). Diversity in sexual desire and expression– and what is perceived as sexual or how desire is experienced and performed – has been understood differently across time and place, and will likely be understood and organised differently within and across cultures in the future (Rubin, 1984; Weeks, 2010).

Understanding sexuality and the sexual body as products of sociocultural processes does not discount biology and embodied experience (Lupton, 2012; Weeks, 2010). A social constructionist approach to sexuality does acknowledge the biological body, not as a deterministic force but as "a set of potentialities which are transformed and given meaning only in social relationships" (Weeks, 2010, p. 20. Also see Lupton, 2012; Marks et al., 2000). That is, the material world – and the sexual body – is understood to arise as meaningful and known through complex, situated sociocultural practices rather than being discovered through direct observation of an independent world (social constructionist epistemologies and

ontologies are discussed further in section 2.2). It is in this way that sexuality can be defined – or constructed – differently, and therefore serve different functions, across various contexts.

1.2.2. Sexuality and sexual health: Contested concepts.

Sexuality and sexual health are polysemic concepts. This is reflected in the volume of definitions and approaches advocated by scholars, health organisations, and government bodies alike (e.g., Giami, 2000; Epstein & Mamo, 2017; Lupton, 2012). These definitions are generally broad, emphasising the complex contribution of a range of biological, psychological, social, and cultural aspects. Many approaches to sexuality, and particularly sexual health, have been influenced directly by the WHO's definition of health as a state of complete physical, mental, and social wellbeing beyond the absence of ill-health (Edwards & Coleman, 2004; WHO, 2010). Accordingly, many definitions of sexuality and sexual health posit that these should be approached affirmatively, such that sexuality is understood as more than just sexual intercourse and sexual health as more than the absence of sexual ill-health (e.g., Heath & White, 2002). In addition to biological or physical aspects of sexuality or sexual health, various definitions or approaches also emphasise the importance of a range of psychological and social elements including interpersonal relationships and intimacy, self-awareness of values, self-esteem, pleasure, identity, communication, and mutual respect (e.g., see Anderson, 2013; Edwards & Coleman, 2004; Graugaard, 2017; Jones, 2019; WHO, 2010). Moreover, regardless of the specific definition or approach being used, sexuality tends to be understood as a fundamental aspect of human experience and wellbeing (eg., Anderson, 2013; Heath & White, 2002; WHO, 2006).

Despite the range of available definitions or approaches to sexuality and sexual health, those put forward by the WHO (2006, 2010) are frequently cited within health and

mental health literature. First put forward in 1975, the WHO's definition of sexual health has been redefined several times to reduce ambiguity, delineate the relationship between sexual and reproductive health[2], define sexuality in relation to sexual health, and incorporate the notion of sexual rights (discussed further in section 1.3.1.) as a necessary part of sexual health (Edwards & Coleman, 2004; WHO, 2010). The current working definitions of sexual health and sexuality are affirmative and aim to acknowledge biological, physical, social, and cultural factors that may shape or otherwise impact sexual health at the level of the individual, couples and families, communities, and nations (WHO, 2010). Sexual health is thus defined by the WHO (2006) as:

> "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (p. 5)

This definition of sexual health is dependent on an understanding of sexuality, and the WHO (2006) defines this in a similarly broad manner:

> "Sexuality is a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can

[2] Sexual health was initially defined as an adjunct of reproductive health, but it is now understood as a conceptually distinct and broader concept that subsumes reproductive health (Edwards & Coleman, 2004; WHO, 2010)

include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors." (p. 5)

Although sexuality and sexual health do tend to be defined holistically in theory, as demonstrated by the WHO working definitions, relevant research, policy, and practice are dominated by a biomedical focus and risk-orientation[3] (e.g., Anderson, 2013; Tolman & Diamond, 2014). This is evidenced by the privileging of biological or somatic aspects of sexuality and the negative consequences or risks associated with sexual expression, often at the expense of a broader enquiry that takes into consideration positive aspects of sexuality and the broader social forces that shape sexual expression and decision-making (Chandiramani, 2010; Heath & White, 2002; Irwin, 1997). For example, in response to criticisms that the WHO's working definitions are inherently ambiguous and difficult to operationalise (see Sandfort & Ehrhardt, 2004; WHO, 2010), a range of measurable indicators have been developed to facilitate the use of 'sexual health' as a concept within research, policy, and practice (WHO, 2010). These indicators focus primarily on biomedical aspects of sexual health including the incidence of sexually transmitted infections (STIs), however, reinforcing the reductive notion that sexual health can be implied through the absence of illness (WHO, 2010). Research funding also tends to be directed to sexuality research that focuses on 'ill-health' or is aligned with biomedical foci more broadly, including disease and risk behaviours, sexual violence, and the identification and treatment of sexual difficulties or dysfunction (Rohleder & Flowers, 2018). This is reflected in the disproportionate focus on STIs, reproductive health concerns, and sexual functioning in

[3] Sexuality research more broadly is dominated by health-related research which, in turn, drives a focus on risk, disease, and dysfunction (e.g., see Jones, 2019)

published academic literature that contains the keyword ‘sexual health’ (Edwards and Coleman, 2004). In this way, psychological, biomedical, and public health approaches to sexuality have traditionally been, and continue to be, largely reductionist.

Reductionist approaches to sexuality drive a focus on individual responsibility and decision-making in relation to disease avoidance and reproductive planning (Irwin, 1997). In doing so, these approaches fail to take into account the material, economic, and social conditions that impact on and constrain individuals’ ability to achieve sexual health, including by impacting the degree to which people can or cannot “exercise control over their sexual lives” (Chandiramani, 2010, p. 352). Moreover, through a narrow focus on ‘health’ located in bodies and biology (Chandiramani, 2010), reductionist approaches fail to consider broader issues relevant to sexuality and sexual health including, for example, “pleasure, survival, intimacy, [… and] recreation” (Flowers et al., 1999, p. 484). While such approaches to sexuality produce useful knowledges, they are also limiting through the absence of a broader orientation to the contexts in which individuals negotiate sexuality and sexual expression (Chandiramani, 2010; Rohleder & Flowers, 2018; Sandfort & Ehrhardt, 2004) and the contexts in which the concepts of sexuality, sexual expression, and sexual health are continually contested and renegotiated.

As discussed previously, definitions and theories of sexuality and sexual health do not only describe relevant experiences or phenomena, but specifically construct these and render them meaningful within specific historical and sociocultural contexts. Epstein and Mamo (2017) have argued that combining ‘sexuality’ and ‘health’ to form ‘sexual health’ sanitises a concept (sexuality) with a much longer and moralised history, thus legitimising this as a focus of medical and other health-based research. Using the concept of ‘sexual health’, which

has no fixed meaning, may therefore serve to "broaden the conception of health to include new conceptions of rights and pleasures" but simultaneously risks "narrow[ing] down the conception of sexuality – [and therefore] constraining the discussion of sexual matters" (Epstein & Mamo, 2017, p. 177). To explore how the concept sexual health is understood and used, Epstein and Mamo analysed scientific articles published in medical and health-related journals and materials available in the wider public media and online. They identified six discourses of sexual health within which both 'sexuality' and 'health' were constructed in "distinctive" ways that incited particular actions by particular actors (both individual and institutional) to achieve "an ideal type of sexual health" (p. 177). Sexual health therefore functioned as "a series of 'solutions'" to specific social problems (p. 177). For example, the most dominant discourse within the academic materials positioned sexual health as the containment of STI transmission via "surveillance, prevention or treatment" (p. 180), and this was the solution to a problem defined by constructing sexuality as 'risky practice' and health as 'risk reduction'. Sexual health not only has many meanings, but these meanings shape how we can conceive of or define sexual health *problems* and the kinds of responses that are appropriate or useful within everyday life, clinical practice, and research.

A narrow biomedical focus (or foci) is limiting in terms of "what sexual health *can be*" and therefore how we might "imagine and develop sexual health interventions" (emphasis in original: Rohleder & Flowers, 2018, pp. 143, 147). Definitions or theories of sexual health (and sexuality) are nevertheless useful in that they offer frameworks through which to "conceptualise and specify goals for health [and health care], interventions, or advocacy" (Sandfort & Ehrherdt, 2004, p. 183. Also see Irwin, 1997). However, in relation to these goals, it is important to orient to the necessarily value-laden and contextualised nature of both sexuality and sexual health. These concepts serve particular functions or achieve

particular actions, including to establish and reinforce normative standards and understandings in relation to sex and sexuality (Barker, Gill, & Harvey, 2018; Hunt, Braathen, Swartz, Carew, & Rohleder, 2018; Loeser, Pini, & Crowley, 2017) and, within an increasingly neoliberal health context, to "establish 'norms' that are used to define people's behaviour as 'healthy' and others who do not fit these norms as 'unhealthy'" (Edwards & Coleman, 2004, p. 192). This point is recognised, often uncritically, by many contributors to this extensive conversation about how sexuality and sexual health should be conceptualised, regardless of epistemological approach[4] (e.g., Irwin, 1997; Tolman & Diamond, 2014; WHO, 2010). Accordingly, it is important to consider "whose values and beliefs are determining and become regulators" of norms in relation to sexual health (Sandfort & Ehrherdt, 2004, p.183). In doing so, it is also necessary to consider how those norms are reproduced over time and the function(s) that they serve. This requires a consideration of the historical context in which the concepts of sexuality and sexual health are continually renegotiated, especially within the context of mental health settings, explored below.

1.2.3. Sexuality over time.

As socially constructed concepts, sexuality and sexual health cannot be understood in isolation of historical and cultural context (e.g., Heath & White, 2002). In this section, I provide a brief discussion of the historical context against which sexuality is popularly and professionally understood in Westernised societies today, both broadly and within the context of mental distress and illness.

Dominant discourses of sexuality in Westernised societies are hetero- and mono-normative and ableist (Barker et al., 2018; Shildrick, 2009): The forms of sex or sexual

[4] Recognition that sexuality and sexual health are not value-free constructs is particularly well aligned with a social constructionist epistemology: See section 2.2.

expression that are broadly perceived to be the most normal, natural, and legitimate are primarily heterosexual (and occurring between non-disabled adults), monogamous, not transactional, and private (Barker et al., 2018; Rubin, 1984). This is defined in contrast to unnatural, abnormal, and less legitimate (often stigmatised) forms of sexual expression including non-heterosexual sexual relationships, non-monogamy, promiscuity, casual sex, sex work, and public sex (Barker et al., 2018; Rubin, 1984). What constitutes normal sex and sexuality is not fixed but, rather, continually (re)negotiated and (re)produced through social interactions and institutions, including in medical and mental health settings (Foucault, 1980; Lupton, 2012; Weeks, 2010).

Sexuality as it is popularly and professionally understood in Westernised sociocultural contexts has been largely shaped by dominant medical and scientific perspectives that arose over the nineteenth and twentieth centuries (Foucault, 1980; Tiefer, 2006; Weeks, 2010). The institutions of psychiatry and psychology (as well as sexology, medicine, and public health) played a major role in producing, reproducing, and reinforcing normative discourses of sexuality over the nineteenth and twentieth centuries with this continuing today (Foucault, 1980; Rubin, 1984; Sullivan, 2003; Tiefer, 2006; Weeks, 2010). These disciplines contributed to the pathologisation and medicalisation of non-normativity in relation to gender, sexuality, and sexual expression (including relationship structure) by defining what is normal and codifying non-normativity as sickness. Although a medico-scientific concern with normal/abnormal distinctions replaced religion's concern with morality, sexuality and sexual health remain highly moralised issues (Marks et al., 2000; Weeks, 2010). Indeed, as discussed in the previous section, *sexual health* is increasingly *re*-moralised within a modern neoliberal health context in which individuals are positioned as responsible for achieving and

maintaining a state of health, and ill-health therefore signals the individual's failure to uphold this duty (e.g., Crawford, 2006; Epstein & Mamo, 2017; Nettleton, 1997).

A medico-scientific approach arose in the nineteenth century involving the classification of sexual practices as healthy and normal, or unhealthy, abnormal and deviant (Marks et al., 2000). The overall goal of these movements was to encourage 'good' sexual behaviours (i.e., those that were monogamous and procreative sex within married couples) and reduce 'bad' sexual behaviours and deviancy (Giami, 2002); a project in which the institutions of medicine, psychiatry, and psychology (and others) were centrally involved. For example, sexuality became a public health concern in the early nineteenth century, where there was a concern with the management of risk and the control of procreation within marriages and reduction of all other forms of sexual activity including masturbation (Giami, 2002. Also see Foucault, 1980).

At this time, there was also a concern with prohibiting procreation among those who were perceived risks to a well-functioning society, including people with mental illness diagnoses due to concerns of heredity madness or psychological deficits (Giami, 2002; Schirmann, 2013). The eugenics movements and associated strategies provided a 'solution' to this concern with the surgical and institutional sterilisation of people with disabilities and mental illness diagnoses such as schizophrenia and bipolar, as well as other social 'undesirables' including non-heterosexual identifying people and sex workers, reaching a peak during and immediately following World War II (e.g., Thompson, 2010). While explicit eugenicist practices are no longer legal in most countries including Australia, there is evidence of ongoing reproductive restrictions within mental health settings. For example, Perry, Freieh, and Wright (2018) have demonstrated that mental health clinicians in the

United States engage in forms of therapeutic social control to "alter contraceptive behaviour" of individuals with serious mental illness (SMI) diagnoses to align with their professional goals and norms (e.g., in particular, to direct women toward long-acting contraceptive interventions: p. 117); but they do this through enabling and educative strategies purported to facilitate self-determination. Researchers working from a range of disciplines and perspectives have suggested that excluding discussions about sexuality from the therapeutic encounter, particularly within the context of prescription of pharmacological treatments that directly impact sexuality and reproductive health[5], may also act as a modern, subtle form of reproductive restriction or sterilisation (e.g., Higgins, 2007a; Montejo, 2019). Sexuality and sexual expression continue to be limited or restricted within the context of mental distress and illness more broadly, for example through the ongoing devaluation of the importance of sexuality in the lives of people experiencing mental distress by (mental) health professionals and broader society. This will be explored in the next sections.

1.3 Sexuality and Sexual Health in Mental Health Settings: Where Do These Fit?

While there can be no final definition of sexuality, different conceptualisations are useful (and limiting) in different ways. In mental health settings characterised by a recovery-orientation – or rhetoric – the most useful approach to sexuality is an holistic, affirmative one that extends beyond a focus on biology and bodies. Sexuality should be included in comprehensive mental health care, and this should include all aspects of sexuality and sexual health including biological, psychological, interpersonal, social, and cultural (de Jager & McCann, 2017). This approach is also best aligned with the perspectives and self-reported

[5] Psychotropic medications can have negative impacts on fertility and foetal development (Galbally, Snellen, & Lewis, 2011; McAllister-Williams et al., 2017). E.g., antipsychotic medications that increase prolactin can cause infertility via anovulation (Montejo, Montejo & Baldwin, 2018).

needs of individuals experiencing mental distress and who access mental health services (discussed further in section 1.3.3.).

In this section, I discuss three focussed reasons why sexuality and sexual health are relevant in mental health settings and justify the need for sexuality research in this area: Mental distress and illness do not negate sexual rights, including the right to pleasure; mental health care in Australia is underpinned by recovery-oriented and person-centred policy (Australian Government, 2013a-c); and individuals experiencing mental distress identify that sexuality is both important to them and under-addressed within mental health settings. Before discussing these points, it is important to acknowledge that I am actively choosing to avoid a risk-orientation and, instead, to centre individuals' self-identified needs.

As a group (or groups), people who experience mental distress or have a mental illness diagnosis tend to have poor objective sexual health outcomes as indicated by the incidence of STIs, unplanned pregnancy, sexual difficulties and dysfunction, and experience of sexual violence. These concerns, elaborated below, require ongoing attention. However, research exploring sexuality and sexual health-related concerns within the context of mental distress and illness tends to focus on issues of risk and the biological dimensions of sexual and reproductive health. That is, there tends to be a focus within the wider literature on those narrow aspects of sexuality that are easier to measure and that are often taken as indicators as sexual health (see section 1.2.2.). For example, de Jager and McCann (2017) conducted a qualitative review of the literature on the sexuality and intimacy needs of people experiencing psychosis over the preceding decade. While there was notably less research on sexual risk in the context of psychosis than two decades ago, the authors identified a major biomedical focus in the literature overall: the most researched issues included HIV, STIs, and sexual

side-effects of psychotropic medication (i.e., sexual dysfunction). Only seven of fifty-six studies within the review had explored needs, desires, and satisfaction in relation to sexuality and intimacy for people who experience psychosis. Importantly, these needs and desires were not especially different to those in the general population, but they were reportedly unmet or ignored by mental health clinicians (de Jager & McCann, 2017: also see de Jager, Cirakoglu, Nugter, & van Os, 2017).

Individuals' needs and desires in relation to sexuality, intimacy, and sexual health often do include, but always go beyond, issues of disease, pregnancy, dysfunction, and violence (e.g., McCann et al., 2019; Quinn & Happell, 2015a). As discussed previously (section 1.2.2.) and elaborated below, biological dimensions and risk are not the only potential aspects of sexuality and sexual health. A dominant focus on these issues in research – including the positioning of these issues as the primary justification or evidence of the need for such research – is therefore an incomplete way to approach sexuality within the context of mental distress and illness. Moreover, focusing on biological and risk perspectives to position sexuality and sexual health as relevant in mental health settings pathologises and problematises the sexuality of people experiencing mental distress, rather than acknowledging that it may be an important aspect of their lives more broadly. This is harmful for people experiencing mental distress because it reinforces negative representations and stereotypes about sexuality in the context of mental illness experiences, therefore limiting how sexuality can be explored and understood within this context. Accordingly, while I acknowledge biological and safety-related aspects of sexual (ill-) health where relevant within this chapter and throughout the research presented in this thesis, I do not focus on or privilege these issues over other dimensions of sexuality. The disproportionate privileging of

these aspects of sexuality and sexual health within both research and clinical practice is an issue that I will return to in Chapter Eight.

1.3.1. Sexual rights: A right to pleasure, dignity, and choice.

Sexual health is often conceptualised through a rights-based perspective that identifies and orients toward a person's sexual rights (e.g., WHO, 2006, 2010). Sexual rights offer a framework for approaching or addressing sexuality in a way that goes beyond health, bodies, and biology (Chandiramani, 2010). Based on "ethical principles of bodily integrity, autonomy, equity, and non-discrimination", sexual rights are both affirmative and safeguarding, seeking to facilitate pleasure and intimacy as well as to protect against violence and discrimination (Chandiramani, 2010, pp. 352-3). As defined by the WHO (2010), sexual rights "protect all people's rights to fulfil and express their sexuality and enjoy sexual health with due regard for the rights of others and within a framework of protection against discrimination" (p. 4). This includes the right to self-determination regarding sexuality, sexual expression, and reproductive choices (Cook, 2000). Sexual rights are therefore not simply a right to have sex when and with whom one wants: they are about dignity and personhood (Chandiramani, 2010). These are also important aspects of the recovery philosophy which underpins mental health practice guidelines in Australia (discussed further in section 1.3.2.).

Within a sexual rights framework, there is a focus on consent in order to determine what sexual behaviours are acceptable, rather than on social or religious mores in relation to gender or marital status for example (Chandiramani, 2010; Petchesky & Corrêa, 2007). Within this framework, disability and mental illness are not grounds for exclusion from sexuality or sexual expression: Sexuality and sexual rights are not negated by illness experiences, including chronic illness or mental illness diagnoses (Cook, 2000; Quinn &

Browne, 2009). In/ability to consent to sex and consequent safety concerns are often positioned as a primary rationale for prohibiting sexual behaviours within the context of SMI diagnoses or acute mental distress (e.g., Brown, Reavey, Kanyeredzi, & Batty, 2014; Maylea, 2019), and this may be a reasonable concern at times (e.g., Quinn & Happell, 2016). However, Maylea (2019) has argued that enforcing indiscriminate prohibition of sex and sexual expression in inpatient settings[6] is not congruent with Australian law nor international human rights law. Although mental health services have a legal duty of care to provide a safe environment, this must be "balanced with the requirement that services only limit human rights in the least restrictive way possible" (p. 7). Indiscriminately prohibiting sexual expression based on admission to a mental health service rather than individual capacity assessments is not aligned with this goal (Maylea, 2019).

1.3.2. Sexuality and recovery-oriented mental health care.

Multidisciplinary mental health practice guidelines in Australia specifically indicate that services should be person-centred and recovery-oriented (Australian Government, 2013a-c). Person-centred care facilitates self-determination by focusing on the individual's values and treatment preferences rather than on the clinician's professional 'treatment goals' (Slade et al., 2014). Aligned with this, recovery-oriented care should facilitate personal recovery (henceforth: recovery) by supporting individuals to develop meaning and purpose within the challenges of managing mental illness experiences. The philosophy of recovery and evidence-base for this is most developed in relation to psychosis, but it has relevance to a wide range of experiences of distress (Slade et al., 2014). Sexuality and relationship needs are an important part of the recovery philosophy (Cook, 2000; Deegan, 1999; Eklund & Östman,

[6] Maylea (2019) discussed this issue within the context of Victoria, Australia.

2010; Quinn & Happell 2015a; Tennille & Wright, 2013). Despite this, sexuality has generally been neglected in relation to recovery-oriented care (Gascoyne, Hughes, McCann, & Quinn, 2016; Tennille, Solomon, & Bohrman, 2014; Pacitti & Thornicroft, 2009).

The concept of personal recovery is nebulous and complex. Recovery has been defined as "a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles" (Anthony, 1993, p. 3). The meaning of personal recovery is often confused with the traditional clinical understanding of recovery as involving a reasonably linear movement from diagnosis and treatment to cure or symptom reduction and, therefore, a return to 'normal' (Slade et al., 2014). In contrast, personal recovery is an individual-led, potentially non-linear process to develop and maintain a meaningful and purposeful life (Anthony, 1993; Leamy, Bird, Boutillier, Williams, & Slade, 2011; Slade et al., 2014). Personal and clinical recovery are often intertwined but can also be experienced separately (Slade et al., 2014). This means that the recovery philosophy can be adopted and incorporated into mental health services regardless of the presumed location or aetiology of mental distress or illness (e.g., neurobiological or psychosocial: Anthony, 1993).

There are many models or frameworks of recovery and recovery-oriented care (Australian Government, 2013b). Commonly emphasised principles and processes include choice, connectedness, hope and optimism, empowerment, identity and recovery of social roles, meaning and purpose, and self-determination (Deegan, 1999; Leamy et al., 2011). Sexuality, intimacy, and relationship needs are potentially relevant to many of these principles including identity, recovery of social roles, self-determination, connectedness, and meaning and purpose. A prominent notion within the philosophy of recovery is the "dignity of risk and the right to failure" (Deegan, 1999, p. 11). In relation to intimacy and sexuality,

this means that people experiencing mental distress should be afforded the right to make choices and not restricted from making decisions that might perceived as 'poor' or 'risky' but are nevertheless available to people with no mental illness diagnosis (Deegan, 1999; Tennille & Wright, 2013). The Australian *National recovery-oriented mental health practice framework* similarly emphasises the need to support individuals' self-determination and autonomy (Australian Government, 2013a, 2013b). This framework also emphasises the tensions that clinicians may encounter in balancing self-determination within medico-legal requirements and duty of care (Australian Government, 2013c); while this is a complex task, appropriate clinical practice in relation to ethical and medico-legal requirements regarding sexual expression and safety are somewhat contested (as discussed briefly in section 1.3.1 and explored further in section 1.4.1.).

Within recovery-oriented mental health care, holistic or multidimensional assessments are not complete without also including sexual and relationship histories (e.g., Australian Government, 2013c) and the exclusion of these topics could have negative effects on the person's recovery (e.g., Quinn & Browne, 2009). This approach to care therefore requires mental health services to support individuals in relation to sexuality and intimacy needs as they are relevant to and valued by the individual. This is directly reflected in multidisciplinary guidelines for mental health practice, which specify that clinicians must address "issues related to […] sexuality, sexual health, sexual identity, gender identity and intimate relationships" where relevant (Standard 6.15, Australian Government, 2013c, p. 16). These guidelines do not elaborate on what it means to explore these issues, however, so it is not clear how this prescribed inclusion should be implemented. This lack of clarity and policy level guidance may contribute to the continuing inadequacy of sexuality-related care within mental health services (discussed further in section 1.4.2.).

The concept of recovery is not without criticism (e.g., see Buchanan-Barker & Barker, 2008; Scott & Wilson, 2011). However, this approach currently underpins mental health practice guidelines in Australia (Australian Government, 2013a, 2013c), meaning that mental health services should be shaped by and function according to these guidelines. Moreover, this concept and approach to mental health care provision offers a useful framework for understanding how and why sexuality and intimacy or relationship needs are directly relevant to mental health care across professions and settings.

1.3.3. Individuals' sexuality-related needs.

Sexuality, intimacy, and relationships are an important part of life for many people experiencing mental distress or who have a mental illness diagnosis, and who engage with mental health services. While the right to sexual health and sexuality is not diminished by illness experiences (discussed in section 1.3.1.), these experiences may impact the way that people experience or engage sexuality and whether they are able to meet their sexual and intimacy needs. Much of the research that has explored sexuality, intimacy, and relationships within the context of mental distress has been specifically in relation to people with SMI diagnoses such as schizophrenia or bipolar disorder (e.g., McCann et al., 2019). Nonetheless, individuals' self-identified sexuality-related needs include issues of risk in relation to disease transmission, pregnancy, and sexual exploitation or violence, as well as broader issues that go beyond these (McCann et al., 2019). For example, consumers'[7] self-identified sexuality-related needs and difficulties include meeting people and initiating relationships, maintaining long-term relationships, negotiating sexual relationship preferences and values, responding to

[7] I use the term 'consumer' when referring to research that has specifically explored the perspectives or experiences of people with SMI diagnoses. Otherwise, I use the more inclusive term 'individual' (see Terminology).

unwanted sexual advances, and the negative effects of mental distress or medication on sexual function and intimate relationships (e.g., de Jager et al., 2017; Lewis & Scott, 1997; McCann et al., 2019; Östman, 2014). These needs clearly diverge from those commonly considered most important by researchers and clinicians, such as disease prevention and family planning strategies. In this section, I briefly outline the relevant literature that explores and describes individuals' sexuality, sexual health, and intimacy needs.

1.3.3.1. Relationship and intimacy needs.

Consumer-based[8] literature indicates that sexuality is an essential part of self and remains so during distress or illness experiences (e.g., Deegan, 1999; Ravenhill, Poole, Brown, & Reavey, 2020; Volman & Landeen, 2007). Individuals consistently report the importance of intimacy and relationships – including romantic and sexual relationships – for their recovery and overall wellbeing (e.g., Boucher, Groleau, & Whitley, 2016; McCann, 2003; Quinn & Happell, 2015a). While individuals may desire sexual intimacy specifically, sexual intimacy and relationships are also perceived as contributing to or supporting a broader need for intimacy and connection with others (Östman, 2014; Quinn & Happell, 2015a). People experiencing mental distress may experience challenges in "establishing, sustaining and maintaining relationships" (McCann et al., 2019, p. 89). These difficulties may be due to the experience of distress itself or economic disadvantage, structural issues (e.g., lack of privacy in shared housing or in inpatient settings), or stigma and discrimination in relation to mental illness diagnoses (e.g., Boucher et al., 2016; Davison & Huntington, 2010; de Jager et al., 2017; de Jager & McCann, 2017; McCann et al., 2019; Perry & Wright, 2006).

[8] I use this term to refer to research that is driven by (self-identified) consumers' needs and experiences or conducted in partnership with consumer advocates or consumer researchers.

Research indicates that mental illness stigma and discrimination are major barriers to meeting sexual and intimacy needs, particularly for individuals with SMI diagnoses and (or) who have experienced stays in psychiatric inpatient settings (e.g., Baker & Procter, 2015; de Jager & McCann, 2017; Wainberg et al., 2016). A critical analysis of articles exploring sex and relationship issues within the context of psychosis (including schizophrenia: n=156) indicated that mental illness stigma impacts on "self-esteem and self-development" and serves as a major barrier to relationship and sexual relationship possibilities (McCann, 2003, p. 645). More recently, a quantitative survey-based study examining the experience of discrimination for people with schizophrenia diagnoses in 27 countries including Canada, the United Kingdom, and United States indicated that sexual and intimate relations were one of four areas in which people experienced the most discrimination (Thornicroft, Rose, & Kassam, 2007). Survey results also indicated that people with schizophrenia diagnoses experienced internalised stigma in relation to sexuality and intimacy. Mental illness stigma may also interact with minority stigma to produce additional difficulties in relation to sexuality and intimacy needs. For example, individuals experiencing mental distress who are sexuality or gender diverse (i.e., claim identities other than heterosexual and cisgender), or those who engage in non-traditional relationship structures or stigmatised sexual practices, may experience a 'double stigma' that contributes to poor self-image and subsequent difficulty in meeting their intimacy and sexuality needs (e.g., Kidd, Veltman, Gately, Chan, & Cohen, 2011).

There is also some evidence that individuals' sexual and romantic partners are negatively impacted by mental illness stigma in the wider community as well as other challenges associated with mental distress and illness (de Jager et al., 2017; Granek, Danan, Bersudsky, & Osher, 2016; Quinn & Browne, 2009). This may contribute to relationship

breakdowns (Granek et al., 2016), the loss of which can also disrupt broader social connections and roles for the individual experiencing distress (Baker & Procter, 2015).

1.3.3.2. Sexual difficulties.

Mental distress and illness, including specific anxiety, depression, and psychotic illness diagnoses, are associated with higher incidence of sexual difficulties in both women and men[9] (e.g., Basson & Gilks, 2018; McMillan et al., 2017; Quinn & Browne, 2009). For example, individuals may experience changes in sexual desire (decreased or heightened) or a specific sexual dysfunction as outlined in the DSM-5 including disturbance in libido, arousal, or orgasm or pain during sexual intercourse (American Psychiatric Association, 2013; Basson & Gilks, 2018; Quinn & Browne, 2009). It is not clear (or agreed), however, what percentage of these difficulties are associated with the distress itself compared with the pharmacological interventions[10] used to treat these experiences (Basson & Gilks, 2018; Pacitti & Thornicroft, 2009; Quinn & Browne, 2009). For example, the aetiology of sexual dysfunction occurring for women with psychotic illness diagnoses is not well understood and could be related to the 'illness' itself, pharmacological treatment, sexual trauma, stigma and consequent poor self-esteem, sociocultural issues, or a combination of these factors (this ambiguity in aetiology, even within biomedical literature, is especially pronounced in relation to women because they have tended to be excluded from pharmacological research: see Basson & Gilks, 2018).

Pharmacological treatments for mental illness diagnoses including antidepressant, antipsychotic, and anticholinergic medications have well documented negative side-effects

[9] Research that examines sexual side-effects of medications generally discusses these experiences in relation to 'men' and 'women' only, presumably referring to cisgender populations. In this section, I am referring specifically to cisgender men and women, but acknowledge that sexual difficulties are not confined to cisgender populations.

[10] The use of pharmacological interventions is driven by a neurobiological approach to mental distress as biological pathology (e.g., Higgins, 2007a)

that directly impact sexual function in women and men (i.e., iatrogenic sexual dysfunction: see Basson & Gilks, 2018; Higgins, 2007a; Quinn, Happell, & Browne, 2012). Non-sexual side-effects of medications such as hypersalivation, nocturnal bed-wetting, and weight gain can also negatively impact sexuality and intimacy, reducing individuals' quality of life (Basson & Gilks, 2018; Davison & Huntington, 2010; Östman, 2014). Iatrogenic sexual dysfunction is often a concern in clinical practice and research because it is often associated with non-adherence to medication schedules and therefore seen as a risk for the exacerbation of the symptoms for which the medication is prescribed (e.g., Cort, Attenborough, & Watson, 2001; Higgins, Barker, & Begley, 2006a; Quinn & Browne, 2009). Iatrogenic sexual dysfunction is highly distressing for many individuals, however, and sometimes more so than other side-effects that do not impact sexuality and intimacy (de Jager et al., 2017; Pacitti & Thornicroft, 2009). This further demonstrates the importance of sexuality and meaningful sexual expression for many individuals experiencing mental distress.

1.3.3.3. Risk: Disease, pregnancy, and violence.

There is evidence that people with (serious) mental illness diagnoses are more likely to experience poorer sexual health outcomes in relation to disease transmission, unplanned pregnancy, and sexual violence than people in the general population (Brown, Dennis, Kurdyak, & Vigod, 2019; Byers, 2011; Hauck, Nguyen, Frayne, Garefalakis, & Rock, 2015; Hughes, Bassi, Gilbody, Bland, & Martin, 2016; Pandor et al., 2015). This might be because people with SMI diagnoses may be more likely to engage in 'high-risk' sexual behaviours that are associated with increased risk of disease transmission and pregnancy (see Gascoyne et al., 2016; Hughes, 2016; Hughes et al., 2016; Pandor et al., 2015). These behaviours include engaging in sexual activities while intoxicated (reducing likelihood of condom use), intravenous drug use, engaging in transactional sex, having casual sexual encounters or

multiple sexual partners, and having sexual partners who are intoxicated or who engage in high-risk behaviours (e.g., intravenous drug use: see Gascoyne et al., 2016; Higgins, Barker, & Begley, 2006b; Hughes et al., 2016). Lower socioeconomic status associated with SMI diagnoses may also be a risk factor for blood borne viruses specifically (e.g., hepatitis C and HIV: Hughes et al., 2016). Due to methodological issues, many of these risk factors are not well understood (e.g., Hughes et al., 2016). Beyond reflecting 'symptoms' of distress, high-risk behaviours may be related to efforts to manage mental illness stigma within the context of intimate and sexual relationships (see Elkington et al., 2013).

There is also evidence that people with SMI diagnoses are more vulnerable to sexual exploitation and experience higher rates of pressured or coerced sex than people who do not have SMI diagnoses (see Gascoyne et al., 2016; Higgins et al., 2006b). Sexual exploitation, abuse, and violence often occurs within the context of domestic and intimate partner settings (Dorsay & Forchuk, 1994), and people with SMI diagnoses may experience higher rates of domestic and intimate partner violence (Howard et al., 2010). Vulnerability to sexual violence may be partially related to individuals' ability to navigate boundaries and preferences within sexual encounters (Higgins et al., 2006b) and to engage in and maintain safe relationships more broadly. Indeed, there is some evidence that sex education programs that included the opportunity to acquire skills in assertiveness and negotiation in relation to values and safer sex practices decreases risk of sexual exploitation (see Higgins et al., 2006b). Institutional contexts also impact sexual behaviour, potentially facilitating 'high-risk' sexual behaviours and vulnerability to exploitation through prohibitive policies that drive patients to engage in covert sexual relations (Brown et al., 2014; McCann et al., 2019; Quinn & Happell, 2015a; Ravenhill et al., 2020. Discussed further in section 1.4.1.).

These are all important issues that may have negative implications for individuals' physical, emotional, and social well-being and may impact negatively on their recovery. Individuals also perceive these issues as sexual concerns. For example, sexual exploitation and (in)ability to consent to sex have been raised by individuals as sexual concerns, particularly within psychiatric inpatient settings (acute or forensic: e.g., McCann et al., 2019; Quinn & Happell, 2015a). Individuals are also aware of and concerned about transmission of STIs and HIV (e.g., McCann, 2010). As discussed previously, however, these are not the only sexual concerns that are relevant or important to individuals experiencing mental distress.

Individuals experiencing mental distress express a desire for their (mental) health providers to support them in relation to engaging and maintaining intimate relationships, including sexual intimacy; minimising or managing sexual dysfunction; and developing skills in negotiating and communicating about consent as well as safety in sexual encounters and intimate relationships (McCann et al., 2019). Consumer participants in a project exploring consumer and nurse experiences in a forensic hospital in Victoria, Australia, expressed a desire for support in relation to engaging and maintaining relationships and sexual intimacy (Quinn & Happell, 2015b). Despite this, evidence indicates that individuals' sexuality and sexual health needs across a wide range of domains – including biological and psychosocial – continue to be inadequately addressed by mental health clinicians across disciplines and settings (e.g., McCann et al., 2019). This will be discussed in the next section.

1.4 Sexuality and Sexual Health in Mental Health Settings: Current Practice

It is generally agreed within the literature that sexuality is a relevant and legitimate part of health and mental health care, and ought to be included in comprehensive, person-centred, and recovery-oriented care (e.g., Byers, 2011; Cort et al., 2001; Higgins, 2009;

Higgins, Barker, & Begley, 2006c; Levine & Scott, 2010; Odey, 2009; Quinn & Browne, 2009; Stevenson, 2004). As discussed previously, it is not clear how this inclusion should be achieved (see section 1.3.2.), nor what constitutes sexuality and what it means to be sexually healthy (see section 1.2.2.). Nonetheless, evidence indicates that individuals' sexuality and sexual health-related needs are under-addressed across health or mental health settings. Moreover, research exploring mental health clinicians' perceptions and practice in relation to sexuality and sexual concerns consistently reports that participants infrequently raise and inadequately address these topics within their practice (e.g., Hughes, Edmondson, Onyekwe, Quinn, & Nolan, 2018; Quinn, Happell, & Browne, 2011b) and this is similar to research findings in other health settings (e.g., Dyer & das Nair, 2013; Gott, Galena, Hinchliff, & Elford, 2004a; McCabe & Holmes, 2014). This was reflected in a retrospective audit conducted in a multi-site community mental health service in Victoria Australia that reported that more than 60% of casefiles for newly-admitted individuals (n=184) recorded no form of sexual health screening[11] within their first 12-week period (Corbett, Elsom, Sands, & Prematunga, 2017). While retrospective audits may underrepresent how often clinicians raise sexuality with individuals, since they may not always record these conversations, these findings reflect evidence in the wider literature indicating that sexuality-related practice in mental health settings in inadequate.

A range of barriers to raising and incorporating sexuality or sexual concerns within clinical practice are commonly reported across health settings and professions. Research has primarily been conducted within the discipline of nursing, including mental health nursing,

[11] Sexual health screening items coded in the audit included sexual side-effects of medications; sexual dysfunction; safe sex; history of sexual abuse; history of sexual offence; reproductive health; relationship issues; and sexual self-esteem (Corbett et al., 2017)

though research involving other disciplines – and particularly other mental health disciplines including psychologists and psychiatrists – has been growing. Reported barriers tend to be similar across disciplines, both within mental health and wider health contexts (e.g., nurses working in other health settings, and general medical practitioners: Dyer & das Nair, 2013; East & Hutchinson, 2013; Gott et al., 2004a). These barriers include embarrassment in relation to topics of sexuality, a reliance on common stereotypes and assumptions, a lack of relevant professional education, and several organisational barriers. These are discussed in the next section. I then identify the main gaps in this literature that will be filled by the research presented in this thesis and outline several research questions accordingly.

1.4.1. Barriers to addressing sexuality in mental health settings.

Many clinicians across health settings and professions experience discomfort in discussing sexuality or sexual health within the therapeutic encounter (Dyer & das Nair, 2013; Gott et al., 2004a; Ussher et al., 2013). Research has demonstrated that nurses working across settings tend to perceive sexuality as a taboo topic that is potentially embarrassing to discuss, both for themselves and the individuals or patients (e.g., East & Hutchinson, 2013; Katz, 2005b; Odey, 2009; Quinn & Happell, 2012). Fear of embarrassing or offending the individual, and consequently damaging the therapeutic relationship, is commonly reported as a reason why nurses may avoid raising the topic of sexuality, though this may be a way to disguise nurses' own discomfort or embarrassment (see Odey, 2009; Quinn et al., 2012; Quinn, Platania-Phung, Bale, Happell, & Hughes, 2018). Researchers have commonly reported that nurses manage these concerns and avoid discomfort within the interaction by waiting for the individual to raise the topic themselves (Higgins, Barker, & Begley, 2008; Katz, 2005b; Odey, 2009; Quinn et al., 2011b). This is problematic since, despite being very willing to discuss sexuality or sexual concerns (see McCann et al., 2019), individuals are

often reluctant to initiate these conversations themselves with any healthcare professional, even when good rapport has been developed (Higgins et al., 2006b; Katz, 2005b; Love & Farber, 2017; McCann, 2003; Odey, 2009). Moreover, it is clinicians' responsibility to explicitly invite discussions about sexuality and relevant sexual concerns within the therapeutic encounter (Higgins et al., 2008; McCann, 2010; Quinn & Happell, 2012; Volman & Landeen, 2007).

Individuals also rarely disclose sexual concerns or difficulties (particularly iatrogenic sexual dysfunction) with clinicians without being asked directly about these (see McCann et al., 2019; Quinn & Browne, 2009). In an Australian study with mental health nurses, most participants acknowledged risk of iatrogenic sexual dysfunction but only four of fourteen participants reported discussing this with individuals (Quinn et al., 2012). Those who did discuss sexual dysfunction with individuals suggested that this was a comfortable way to raise an otherwise potentially embarrassing topic. This reflects findings from other settings indicating that body function and iatrogenic sexual dysfunction are "safe topics" relative to other aspects of sexuality (Astbury-Ward, 2011, p. 261) and that nurses may feel more comfortable in raising sexuality when they can approach this from a medicalised perspective (McCabe & Holmes, 2014). Despite a reported desire to educate individuals about the potential side-effects of medications, many nurse participants in the Australian study were concerned that doing so might reduce adherence to medication schedules (Quinn et al., 2012). This is aligned with a concern identified in the wider literature that side-effects impacting sexuality and intimacy can contribute to non-concordance with medication schedules (e.g., Cort et al., 2001; Higgins et al., 2006a). Clinicians nevertheless have an ethical duty to discuss all "indications and contraindications of treatment prescribed" with individuals

(Quinn & Browne 2009, p. 198), including the potential impact on sexuality and sexual function.

The taboo nature of sexuality may be especially heightened in mental health settings because sexuality has historically been excluded from, or pathologised within, this context (discussed in section 1.2.3.). Clinicians may perceive sexuality as an *inappropriate* topic within mental health settings. For example, mental health clinicians report concern that raising discussions about sexuality will exacerbate individuals' distress (e.g., Quinn et al., 2018), though this concern is not supported by available evidence (see McCann et al., 2019). Moreover, clinicians may be afraid that raising or addressing sexuality and sexual concerns will be interpreted as unprofessional or inappropriate by either the individual or their colleagues. As part of a larger study, Quinn and Happell (2012) reported that mental health nurses avoided recording discussions about sexuality or sexual health concerns in casefiles where colleagues might read them. Sexuality may also be perceived as an *unimportant* topic within mental health settings, where clinicians draw on a common assumption that people with (serious) mental illness diagnoses, especially schizophrenia or psychotic disorders, are less sexual than others or asexual (Corbett et al., 2017; Quinn & Browne, 2009). Mental health clinicians across professions, including psychiatrists, continue to "underestimate the importance of the sexual aspects of their psychiatric patients' lives" (Basson & Gilks, 2018, p. 2).

More broadly, clinicians across health and mental health settings appear to draw on a range of common assumptions or cultural discourses to explain or justify their avoidance of sexuality and sexual health within their clinical practice. Clinicians perceive that raising sexuality or sexual concerns with individuals may be unimportant, inappropriate, or

especially difficult based on the individual's perceived characteristics including gender, age-group, religion, sexual orientation, or relationship status (i.e., whether they are in an intimate relationship: Corbett et al., 2017; East & Hutchinson, 2013; Quinn et al., 2012; Ussher et al., 2013). For example, clinicians may perceive that women are less sexual than men (Higgins, 2007b), or that sexuality is not yet relevant for younger people (McCabe & Holmes, 2014) or no longer relevant for older people (Gott, Hinchliff, & Galena, 2004b; Hordern, 2008). Clinicians also report heightened discomfort in raising sexuality with individuals who differ from them in relation to a range of social identity categories including gender, age-group, and culture or ethnicity (e.g., Attalah et al., 2016; Higgins et al., 2008; Hughes et al., 2018; Quinn et al., 2012).

In broader health settings, clinicians commonly perceive that sexual concerns are beyond the remit of their own professional role and should be addressed by clinicians from another profession (Dyer & das Nair, 2013). Within mental health settings, nurses often perceive that psychiatrists should be responsible for raising and addressing specific sexual concerns including iatrogenic sexual dysfunction because psychiatrists prescribe the medications (e.g., Hendry, Snowden, & Brown, 2018; Quinn, 2013). However, although the relevance of sexuality and sexual health within psychiatric practice is recognised (e.g., Stevenson, 2004), the available evidence indicates that psychiatrists do not regularly enquire about or address sexuality within the therapeutic encounter (e.g., Levine & Scott, 2010; Nnaji & Friedman, 2008; Zatloff, Silke, Philip, & Ward, 2020). Similar to this, evidence suggests that psychologists also tend to be a preferred referral source for sexual concerns by other clinicians including general practitioners (GPs: e.g., Reissing & di Giulio, 2010; Ussher et al., 2013), but they infrequently raise sexuality or sexual concerns within their everyday practice (Reissing & di Giulio, 2010; Miller & Byers, 2012). This is despite the espoused importance

of a biopsychosocial approach within applied psychology (e.g., Crossley, 2008; Hatala, 2012) and an understanding within psychology that sexuality and sexual expression are related to mental health and wellbeing in important ways (Byers, 2011; Love & Farber, 2017; Southall, 2017).

A common finding reported in the literature is that mental health clinicians across professions do not receive adequate professional education in relation to sexuality and sexual health and, consequently, report a lack of confidence and perceived competence in relation to these topics. In a qualitative focus group study that included mental health nurses and psychiatrists in the United Kingdom, participants reported that they lacked confidence in raising sexual concerns within clinical practice and perceived this as being a consequence of their limited knowledge and skills in relation to sexuality and sexual health (Hughes et al., 2018). Research outside of Australia indicates that psychiatry training programs generally do not provide adequate training in relation to sexuality and sexual history taking (see Rele & Wylie, 2007; Sreedaran, 2019). A survey conducted in the United Kingdom indicated that participating psychiatrists (n=76) did not routinely ask women with schizophrenia diagnoses about their sexual function and less than one third reported feeling competent in doing so (Nnaji & Friedman, 2008). Research in Australia and elsewhere has similarly reported that nurses working in health and mental health settings are undertrained in relation to sexuality (e.g., East & Hutchinson, 2009; Quinn, 2013), particularly beyond biomedical aspects of sexual and reproductive health (Astbury-Ward, 2011; Higgins, Barker, & Begley, 2009).

Psychologists are also reportedly undertrained in relation to sexuality. In a Canadian survey study, most participating clinical psychologists (n=188) reported feeling comfortable with discussing sexual concerns with individuals (though far fewer reported actually raising

sexuality with clients frequently), but almost half of participants felt that their comfort was negatively impacted by a lack of training, and less than half of participants had received any relevant formal training (Reissing & Di Giulio, 2010). Miller and Byers (2012) have reported that, among psychologists in Canada, higher quantities of relevant training was related to both higher perceived self-efficacy, or competence, in addressing sexual health concerns and more frequent enquiries about such concerns within clinical practice. Particularly where clinicians *are* addressing sexual concerns, even infrequently, inadequate training also presents an ethical concern because clinicians may address sexual concerns ineffectively or in a way that is misaligned with best practice guidelines (see Reissing & Di Giulio, 2010).

Several communication models have been developed that aim to support clinicians working across a range of health settings in raising and addressing sexuality concerns with individuals or patients. These include the PLISSIT model of sexual counselling (Annon, 1976), the updated EX-PLISSIT model (Taylor & Davis, 2006), and the BETTER model (Mick, Hughes, & Cohen, 2004). These models have been widely discussed and explored within the discipline of nursing in particular, as well as being communicated with nurses through continuing professional development materials, though most often in relation to general or oncology nursing rather than mental health nursing (e.g., Evans, 2013; Higgins et al., 2006c; Hordern, 2008; Katz, 2005a, 2005b; Quinn & Browne, 2009; Quinn, Happell, & Welch, 2013b; Salkeld, 2015). Various critiques have been made in relation to these models, particularly PLISSIT: This is the oldest and most well-cited of the models, but it is individualistic in its approach to sexuality and assumes an outdated, paternalistic interrelationship between clinician and individual (i.e., one that is not compatible with the person-centred approach now positioned as best practice: Hordern, 2008; Irwin, 1997). The

BETTER model does not present these same problems and has therefore been favoured by some scholars (e.g., Hordern, 2008; Quinn, Happell, & Welch, 2013a).

Researchers in Australia explored the utility of the BETTER model in supporting mental health nurses working in Australia to raise sexuality within their practice (Quinn & Happell, 2012; Quinn et al., 2013a). Participating nurses did report improvements in their practice following a brief education session about sexuality within the context of mental distress and introduction of the BETTER model (Quinn & Happell, 2012) and they perceived that these improvements were sustained over a two-year period (Quinn et al., 2013a). The nurses perceived that the BETTER model was too structured, however, and felt that it was the education sessions rather than the communication model that had supported them to improve their sexuality-related practice (Quinn & Happell, 2012; Quinn et al., 2013a, 2013b). The authors concluded that, rather than a primary focus on communication skills, knowledge and awareness-building to facilitate "nurses to value the importance of including… sexual health in their practice" may enable improved practice (Quinn et al., 2013b, p. 22). This is aligned with some evidence that improved professional education can facilitate improved sexuality-related practice and comfort, as discussed above; however, this assumes that there is a direct pathway between improved sexuality-related knowledge (and communication skills) and sexuality-related clinical practice. Every available communication model, including the BETTER model, also makes this assumption (also see Ussher et al., 2013). These therefore fail to consider many of the barriers discussed within the relevant literature beyond embarrassment and a dearth of education, including organisational and structural barriers, elaborated below.

Some research has demonstrated that clinicians working across a variety of health settings perceive structural and organisational barriers to addressing individuals' or patients' sexuality and sexual health needs. A lack of time is commonly reported as a barrier identified by nurses, physicians, and mental health clinicians working across a range of health settings (but not mental health settings: Dyer & das Nair, 2013; Gott et al., 2004a; Hordern, 2008; Ussher et al., 2013). Time constraints are interpreted differently across studies, however, from reflecting an organisation's explicit shared values and practices that guide clinicians' practice (Dyer & das Nair, 2013) to a justification used by participating clinicians to explain their own inadequate practice (Ussher et al., 2013: also see Quinn & Browne, 2009). These differences likely reflect the epistemological underpinning and approach to interpretation taken by the researchers (realist/positivist or relativist/critical, respectively). Regardless of how this is interpreted, evidence suggests that clinicians across health settings often talk about perceived time constraints when asked about their sexuality-related practice.

At an organisational level, sexual expression within psychiatric inpatient settings is commonly prohibited or ignored by those institutions (including acute, semi-acute, and forensic settings: Deegan, 1999; McCann, 2003; Quinn & Happell, 2015a). This is despite evidence that individuals within these settings do engage in intimate and sexual relationships and encounters with others (e.g., Hales, Romilly, Davison, & Taylor, 2006; Quinn & Happell, 2015a; Ravenhill et al., 2020; Warner et al., 2004). For example, a survey of directors of longer term, psychiatric inpatient settings in the United States (n=78) indicated that only two thirds of institutions had formal policy in relation to sexual behaviour, and these tended take a punitive rather than therapeutic or supportive approach to individuals' sexuality and intimacy needs and behaviours (Wright, McCabe, & Koorman, 2012). Although prohibitive policies and practices are often positioned as keeping both individuals and clinicians safe (i.e., from

harm or abuse, and legal or ethical implications, respectively: e.g., Maylea, 2019), these create risks and challenges for both groups. Prohibitive policies reduce individuals' opportunities for dignified sexual expression and drive them to find alternative and hidden spaces for this (Brown et al., 2014; McCann, 2003; Ravenhill et al., 2020). These policies can also create challenges for clinicians by directing them to engage in surveillance and management behaviours rather than facilitating them to support individuals to safely meet their sexual and intimacy needs (Quinn & Happell, 2015a). Conversely, absent or insufficient guidance about how to respond to sexual expression and relationships within these settings creates a situation of uncertainty for clinicians and other staff who must then rely on local and personal judgements to decide whether behaviours are appropriate or risky and how to respond to these (Ravenhill et al., 2020). No-sex policies, or the absence of formal guidance in relation to sexuality and relationships, may therefore represent organisational barriers for clinicians to providing person-centred and recovery-oriented mental health care in a way that maintains both individuals' dignity and their own professional accountability.

1.4.2. An issue unresolved: The current project.

Despite ongoing and growing research interest in this area, research involving both mental health clinicians and individuals who access mental health services indicates that sexuality and sexual health needs continue to be inadequately addressed within mental health settings. Additional or improved education for clinicians is often heralded as 'the solution' to this problem (e.g., Hendry et al., 2018; Quinn et al., 2013b). Improved education may be important, as clinicians cannot put into practice knowledge that they do not have; but knowledge is not necessarily translated directly into practice (also see Ussher et al., 2013). Moreover, relevant information and educational materials are currently available for clinicians who might decide to access these (e.g., continuing professional development

materials: Anandappa & Gad, 2013; Evans, 2013; Higgins et al., 2006c; Katz, 2005a, 2005b; Tennille & Bohrman, 2017). Evidence that individuals' sexuality needs are still under-addressed in mental health settings indicates that clinicians across disciplines are either (or both) not accessing this information or not putting it into practice in a way that individuals perceive as adequate. It is unclear within the relevant literatures why sexuality continues to be inadequately addressed in mental health settings, or how this can be improved.

While previous research has indicated a range of barriers that may constrain clinicians in addressing individuals' sexuality-related needs (as discussed in section 1.4.1.), there appears to be little understanding of how clinicians currently perceive sexuality and sexual health as these are relevant to their work. Few studies have explored mental health clinicians' understanding or conceptualisation of sexuality specifically. A significant exception to this is the work of Higgins (2007b: also see Higgins et al., 2008, 2009) who conducted a grounded theory study to explore how mental health nurses working across multiple sites within a single service in Ireland conceptualised and approached sexuality. Higgins reported that participating nurses understood and oriented toward sexuality within their work primarily through veiling processes that functioned to silence sexuality. 'Veiling sexualities' was identified as the core category within the analysis, which delimited and directed its development. The analysis was therefore focussed on how and why nurses silenced sexuality (e.g., driven by a "desire to protect their own and clients' vulnerabilities": Higgins, 2007b, p. 106), with little scope to explore different or broader understandings of and approaches toward sexuality within the context of mental distress. While silencing discourses and practices may be primary ways in which mental health clinicians understand and approach sexuality and sexual health within their work, it is not clear from the literature how clinicians make sense of sexuality including across disciplines and geographical settings.

Health professionals are members of society and work within disciplines that are constructed and operate within a social context (e.g., Heath & White, 2002; Kleinman, 1980; Lupton, 2012). Clinicians therefore draw on and reinforce existing wider discourses of sex, sexuality, and sexual health (as well as mental distress) within their professional practice (Irwin, 1997). Given the broader context of absent or limited relevant professional education (i.e., throughout pre-registration and specialisation training) and clear guidelines or support at the levels of workplace and professional policy, clinicians must be drawing on broader resources and personal experiences or understandings to make sense of sexuality within their professional practice and decide how to respond to or incorporate this within their work. For example, a large survey-based study in the United States (n=486) indicated that personal factors including experience of intimate relationships, level of religiosity, and early family sexuality communication were all related to and impacted on medical student's self-reported comfort and competency in relation to sexual health (West et al., 2012). The idea that clinicians' non-professional perceptions and beliefs may shape the way that they approach sexuality within their clinical practice has also been acknowledged in the nursing literature (e.g., East & Hutchinson, 2013; Odey, 2009), but the ways in which these might shape their current perceptions and practice in relation to sexuality have not been well investigated.

The continued inability to improve the way that individuals' sexuality-related needs are addressed within mental health settings may be, in part, because clinicians have varied and limiting perceptions of sexuality and sexual health as they are relevant to the lives of individuals accessing those services. McCann (2003) has suggested that clinicians "may need to examine their own attitudes, values, fears and beliefs" in relation to sexuality before they are able to support individuals with their sexuality and relationship needs (p. 646). Similarly, researchers may need to better understand how clinicians currently perceive sexuality and

sexual health in their work in order to facilitate sustained improvements in relevant mental health practice. This was one of the main aims in this thesis.

Research exploring sexuality and sexual health in mental health settings has tended to focus on a single profession or on the experiences of clinicians working within a single service, or both. These foci have tended to be mental health nursing (e.g., Evans, 2011; Higgins, 2007b; Quinn, 2013; Quinn et al., 2018) and psychiatric inpatient settings (acute and forensic: e.g., Brown et al., 2014; Quinn & Happell, 2015a-c; Ravenhill et al., 2020), respectively. Some research in the United Kingdom has also started to explore the perceptions of psychologists (Southall, 2017) or of multiple disciplines working in community mental health settings (Hughes et al., 2018; White, Haddock, & Varese, 2019). Accordingly, far less is known about psychologists' and psychiatrists' perceptions of, and responses to, sexuality and sexual health; but available evidence indicates that theirs are similar to nurses' experiences (discussed in sections 1.4, 1.4.1.). Similarly, less is known about how clinicians respond to individuals' sexuality, sexual health, and intimacy needs in settings other than psychiatric inpatient settings where individuals' ability to consent to sexual activity may be less contested (e.g., in community outpatient and private settings).

Moreover, much of the existing relevant research has been conducted in Ireland, North America (Canada and United States), and the United Kingdom. While there is some Australian-based research with mental health nurses, much of this has been generated by one group of researchers across two projects. One project worked with a small group of participants at a single site in Queensland to first understand participants' experiences in addressing sexuality and then to develop and qualitatively evaluate an educational

intervention[12] (Quinn, Happell & Browne, 2011a, 2011b, 2012; Quinn et al., 2013a, 2013b). The second project explored mental health nurse and consumer perspectives of sexuality and intimacy within a forensic mental health setting in Victoria Australia (Quinn & Happell, 2015a-c; Quinn & Happell, 2016). These projects have generated important insights and made valuable contributions to the field but, beyond this, little is known about mental health clinicians' perceptions of sexuality within an Australian context.

Mental healthcare is increasingly multidisciplinary. The 'mental health workforce' in Australia comprises a rage of disciplines including psychologists, psychiatrists, and mental health nurses (Australian Institute of Health and Welfare, 2018; Australian Government, 2013c). Individuals accessing mental health services may encounter clinicians from various disciplines and across multiple settings, from specialised hospital, residential, and community mental health settings to private office-based settings, both during a specific period of distress and across their lifetimes (Australian Institute of Health and Welfare, 2018). Accordingly, it is important to explore the perceptions of mental health clinicians from a range of disciplines and across settings. I chose to include specialist mental health nurses[13] and psychiatrists because their experiences have commonly been explored singularly or within psychiatric inpatient or residential settings. I chose to include psychologists because their perceptions are under-researched, especially in an Australian context, despite evidence that they are a preferred referral source for sexual concerns by other clinicians including psychiatrists and GPs (discussed in section 1.4.1.). Exploring the perceptions of clinicians from three professions and who are working across multiple settings in Australia will provide insight

[12] This was the lead author's PhD project (Quinn, 2013).
[13] Specialist mental health nurses in Australia have additional formal education in mental health nursing at a Graduate Diploma or Master level.

into how sexuality might be understood similarly or differently within and across professions and settings.

This thesis aims to develop an understanding of the perceptions of sexuality and sexual health for three groups of professionals working in Australian mental health settings: Psychologists, psychiatrists, and mental health nurses. In addition to three research questions outlined below, the project aims to acknowledge the social, cultural, political, and historical context that shapes how participants understand and make meaning in relation to sexuality and sexual health, and how this, in turn, might shape the experiences of both clinicians and individuals within mental health settings. This orientation is driven by the methodological framework used in this thesis, outlined in Chapter Two. Overall, this project will contribute to developing a deeper understanding as to why mental health clinicians may not adequately address individuals' sexuality and sexual health needs. The project will therefore contribute to filling several current gaps in the sexual health and mental health literatures and promote discussion and consideration of sexuality and sexual health in health care. In doing so, the thesis will contribute to important scaffolding from which further research and interventions can be developed to improve the provision of sexuality-related care in mental health settings and, therefore, improve individuals' experience of care within those settings.

1. How do participants conceptualise sexuality and sexual health?
2. How do participants perceive sexuality as being relevant to their clinical practice?
3. How do participants orient toward, or away from, sexuality and sexual concerns in their work?

1.5 Overview of Thesis

This chapter has outlined the relevant literature(s), drawing on research from a range of disciplines concerned with sexuality and sexual health, health care, and mental health care. I described the polysemic nature of sexuality and sexual health and briefly outlined the historic situatedness of these concepts, including in relation to mental distress and illness. I argued that sexuality is relevant within mental health settings and demonstrated how such an argument can be achieved without pathologising the sexuality of individuals experiencing mental distress. I then explored in detail what is currently known about mental health clinicians' sexuality-related practice and identified major gaps in the literature that will be addressed by the current project.

In Chapter Two, I will outline the theoretical and conceptual frameworks adopted in this thesis and provide an overview of the research design (exploratory, qualitative design). More specifically, I discuss the philosophical framework underpinning the thesis and situate the project within a critical health psychology paradigm. The research design and method are also outlined in detail, despite the presentation of some analyses in the form of prepared or published manuscripts. This is to ensure maximal transparency because, as a hybrid thesis, not all of the results chapters are presented as manuscripts (i.e., including a method section) and the method sections in the presented manuscripts are truncated due to journal word limits. Chapter Two also includes a detailed discussion in relation to quality, ethics, and reflexivity within qualitative research as relevant to this thesis. This discussion in relation to reflexivity within the current project is continued in Chapter Three (a submitted manuscript), which explores a specific methodological dilemma that I encountered during data generation. This reflexivity provides a frame through which to understand the other work that I present in

this thesis and, in this way, contributes to transparency and credibility of the research presented.

Results from four critical thematic analyses are presented in Chapters Four to Seven. These chapters represent four independent analyses, not a detailed report for four overarching themes from one analysis (explicated in section 2.5.2.). Chapter Four presents the results from an analysis in response to the first research question(s): How do participating clinicians conceptualise sexuality and sexual health? This is followed by three chapters, each comprising a manuscript that is published (Chapters Five and Six) or prepared for publication (Chapter Seven) in relevant peer-reviewed academic journals. These chapters present three analyses related to the second and third research questions: How do participating clinicians perceive sexuality as relevant to their roles; and how do they orient toward, or away from, sexuality within the mental health settings where they work?

The discussion in Chapter Eight brings together the results from all four analyses and synthesises these in relation to the broader aims of the thesis and relevant literature to make recommendations for practice and future research regarding sexuality and sexual health in mental health settings.

CHAPTER TWO: Methodology and Research Design

2.1 Introduction

In this chapter, I outline the theoretical framework (social constructionism) and methodological framework(s) (critical psychology and critical health psychology) that underpin this project. Together, these frameworks directed the qualitative method and research processes that were selected to generate and analyse the dataset in relation to the project aims within this thesis. These processes are outlined, with particular attention paid to the method of data analysis that was used to generate four analyses presented in Chapters Four to Seven. Finally, I discuss considerations in relation to quality, ethics, and reflexivity in qualitative research that were relevant to and shaped the research presented in this thesis. Overall, the discussion presented in this chapter represents a non-linear process of learning over years, and I have endeavoured to make note of or orient toward my learning (and missteps) where relevant.

2.2 Theoretical Framework: A Social Constructionist Approach

In this section, drawing primarily on the work of Burr (2015a), I outline a social constructionist approach that underpins this thesis. This includes a discussion of two broad approaches within social constructionism that Burr refers to as 'micro' and 'macro' social constructionism, and how both have contributed to shaping the way that I approach data generation and analysis. Throughout the section I acknowledge several critiques of a social constructionist approach, and contentions and tensions that arise within and between various social constructionist perspectives, as relevant to this thesis.

As a broad theoretical orientation, social constructionism does not provide a single recipe for approaching phenomena, but rather an array of approaches to understanding the

social world, doing research, and generating knowledge (Burr, 2015a). Several core assumptions tend to underpin these approaches (social constructionist approaches may share only one or several of these: Burr, 2015a). Social constructionist perspectives understand knowledge and social phenomena as being constructed and made meaningful through social processes including language, rather than pre-existent or independent of human thought (Burr, 2015a). Language is therefore understood as being active in meaning-making practices rather than a passive reflection of thought or a window to direct observations of an external world. Not only are meaning-making practices social, but they change over time and place; knowledge is therefore specific to the cultural and historical context within which it is generated (Burr, 2015a). This also means that knowledge claims cannot be neutral or value-free (i.e., 'objective'), regardless of where, how, or by whom they were generated (including by researchers drawing on social constructionism, discussed further below: Burr, 2015a). Indeed, within social constructionist approaches there is scepticism about taken-for-granted assumptions of how the world is and how we may come to know it. These approaches are critical of positivist, essentialist, and universalist knowledge claims, including those generated within mainstream psychology and psychiatry (Burr, 2015a. But this does not mean that such knowledge has no value, as discussed in section 2.3).

The rejection of an essential 'truth' that is independent of social processes, universal, and discoverable is indicative of a relativist epistemology, which underpins the assumptions discussed above and is central to social constructionism (Burr, 2015a). By troubling the realist concept of a final 'truth', relativist approaches emphasise the plurality of situated truths, or knowledge claims: all claims to truth are "partial both in the sense of being only one way of seeing the world among many possible ways and in the sense of reflecting vested interests" (Burr, 2015a, p. 9). The focus of relativist research endeavours is thus not on

discovering ‘what is true’ but rather on how knowledge claims are (re)produced through social processes and interaction, and what they achieve (Burr, 2015a; Lupton, 2012). This ignites the possibility of interrogating and (re)conceptualising social phenomena to better serve society, for example in ways that are more socially equitable, and this is a strength of social constructionist approaches.

This strength is simultaneously a criticism, however, because social constructionism and the knowledge claims it generates are also situated and partial (Burr, 2015a; Lupton, 2012). Critics challenge the utility of relativist paradigms on grounds that knowledge claims cannot be evaluated (or rejected) within an approach that apparently “descend[s] into […] nihilism if taken to its logical conclusion” (Lupton, 2012, p. 10; also see Burr, 2015a). Scholars using social constructionist approaches respond to this criticism by emphasising that the aim of their work is to produce alternative was of understanding particular phenomena that may be compared against others, often to the status quo or dominant truth claims, for “their fruitfulness for insight rather than their verisimilitude” (Lupton, 2012, p. 10).

A more focussed criticism in relation to a relativist approach has been raised by scholars who use critical realism[14]. They argue that there is no sense in asking questions about the world from a relativist *ontological* position (e.g., Willig, 2016). A critical realist approach is therefore characterised by a relativist epistemology and realist ontology, whereby there is a direct orientation to the real material references on or around which social processes of meaning-making are enacted (Burr, 2015a; Willig, 2016). However, a broadly relativist approach does not deny the existence of a material world; rather, it emphasises that reality

[14] Critical realism shares many tenants with social constructionism, but scholars who take a critical realist approach do not all agree whether this fits within the broader category of social constructionism (also see Braun & Clarke, 2013; Burr, 2015a).

comes to be known, made meaningful, and transformed through social processes, interactions, and language (Burr, 2015a). For example, social constructionist (relativist) approaches generally do not claim that bodily experiences are not 'real' but emphasise that these are "inevitably known and interpreted via social activity" (Lupton, 2012, p. 9). As discussed briefly in Chapter One (see section 1.2.1.), sexuality and the sexual body can be understood within a social constructionist approach as being built up on a material reality that is only known, or rendered meaningful – not 'discovered' – through social processes.

As stated earlier, social constructionism is not one monolithic approach or framework. A broad but useful distinction can be made between 'micro' and 'macro' social constructionist approaches (Burr, 2015a). Within micro social constructionism, there tends to be a focus on how people construct themselves and others through language in interaction, and how people use language to achieve actions in talk and, therefore, in the social world. This approach is generally associated with discursive psychological approaches (as well as micro sociological theories such as symbolic interactionism). Within macro social constructionism, researchers attend broadly to power as it is embedded in social structures, social relations, and institutional practices, often seeking to critically interrogate how these social conditions (re)produce social inequality (Burr, 2015a; Weedon, 1997). This approach has been strongly influenced by poststructuralist theorists including Michel Foucault (Foucauldian discourse analysis is one analytic method associated with this approach, for example: Burr, 2015a; Lupton, 2012). Within this macro approach, social practices including the 'individual' and 'sexuality' are understood as being shaped and constrained by the discourses available within the relevant historical and sociocultural context. Here, 'discourse' refers not to language itself, as in micro approaches, but to a "systematic [and] coherent set of images, metaphors and so on that construct an object [or social phenomenon] in a particular

way"[15] (Burr, 2015a, p. 236). In this thesis, my approach to data generation and analysis[16] was shaped primarily by a macro social constructionist approach, discussed further below, though I also drew on insights from micro social constructionism where useful.

Within macro social constructionism as I draw on this, discourse, knowledge, and power are inextricably intertwined. The discourses available within a society (or around an object) at any particular time constrain what is 'knowable' and 'sayable', and therefore have implications for the way in which we are able to act and (re)organise social structures. That is, discourses produce knowledge – or ways of understanding the world – that delimit what actions are possible or coherent within a particular time and place (Burr, 2015a). At any time, there are multiple and competing discourses in relation to a particular phenomenon within a discursive field, and therefore multiple ways of understanding the world and experiencing the self. Some discourses will be dominant in that they have more authority than others to identify 'truth'; that is, they produce knowledge that is positioned as 'correct' and common sense (Burr, 2015a; Weedon, 1997). Dominant discourses generally represent and reinforce the interests or values of specific, dominant groups (Burr, 2015a); however they are always able to be challenged through subversion or resistance. This is because alternative (usually marginal) discourses simultaneously make available alternative ways of navigating or experiencing the world that resist or challenge the status quo reproduced through dominant discourses (Weedon, 1997). Power is therefore a relational force within this approach, not *held* by or residing within a person or group but *exercised* by acting on (or resisting) particular knowledges that are (re) produced through discourse (Burr, 2015a; Lupton, 2012; Weedon, 1997).

[15] Discourse is understood similarly in poststructuralist approaches (e.g., see Lupton, 2012; Weedon, 1997).
[16] I used constructionist or critical thematic analysis, discussed further in section 2.5.

Although macro and micro constructionist approaches are different, and often in conflict, they are not mutually exclusive. Some scholars, including Wetherell (1998), have worked to combine these in order to "take account of both the situated nature of accounts as well as the institutional practices and social structures within which they are constituted" (Burr, 2015a, p. 26. Also see Willig, 2015). While (dominant) discourses work to (re)produce broad social structures, for example at an institutional level, these can also be observed as being played out at a 'micro' level between individuals who draw on, and are constrained within interaction by, the discourses available to them. Concomitantly, these (inter)actions "contribute to 'macro' dialogues between discourses" because they serve to reproduce and perpetuate, or challenge and resist, dominant discourses (Guilfoyle, 2003, p. 334). For example, the interaction between a clinician and individual within a mental health setting will be shaped by the relevant discourses available to these individuals; they may draw on or challenge various discourses to build up particular accounts of the world and make sense of the interaction, including each of their roles within that interaction (e.g., the clinician as 'healer' or 'professional', and the individual as 'distressed', 'ill', or 'mad'). Those situated accounts – or ways of navigating and negotiating the encounter as meaningful – are not independent of the sociocultural context in which they are produced.

The multiplicity of possibilities for orienting toward the world through social constructionism demonstrates the inherent flexibility of this broad theoretical paradigm. Researchers using social constructionism are able to draw on and orient towards different aspects or potentialities of the approach(es) that are most useful for addressing (or directing) their project aims, both within and across entire projects, datasets, or individual analyses. This allows different questions to be asked and interpretations generated in relation to the phenomenon of interest within one dataset across analyses. Within this thesis, using this

theoretical framework flexibly this has enabled me to produce multiple analyses that are all broadly grounded in a critical, social constructionist perspective, but whose analytic foci shift to draw on different discursive insights and produce more descriptive or more latent interpretations (Braun & Clarke, 2013; Willig, 2017). While these interpretations may be in tension with one another, they do not compete to define a final truth; rather, they sit alongside one another to provide a nuanced, yet situated and partial perspective in relation to a complex phenomenon (Willig, 2017).

Approaching sexuality as socially constructed and continually renegotiated, rather than a universal biological mandate, allowed me to explore how the concept is understood within particular contexts (i.e., mental health settings), what those conceptualisations achieve and how they shape practice (i.e., how might they be limiting and how might they harm some groups of people), and what opportunities there might be for conceptualising sexuality differently. Overall, a social constructionist framework as used in this thesis has enabled me to focus on how participants conceptualise relevant concepts, while attending to the broader cultural context in which this occurs; how they account for their everyday practice in relation to sexuality; and, more broadly, how the wider institutional context shapes and reinforces particular ways of conceptualising or approaching sexuality within mental health settings, according to participants' own accounts.

2.3 Methodological Framework: Critical Health Psychology

The methodological framework in this thesis is guided broadly by a critical psychological approach and, more specifically, by a critical health psychological approach. In this section, I give a brief account of the theoretical and methodological principles shared by these approaches and the compatibility between critical approaches and social

constructionism more generally[17]. I then discuss why critical health psychology provided an appropriate and flexible methodological framework for this thesis.

Critical psychology encompasses a range of 'psychologies', including critical health psychology, that are theoretically and methodologically diverse (Fox, Prilleltensky, & Austin, 2009). These critical psychologies tend to share some important principles that can be mapped closely onto those of a broad social constructionist approach. First, critical psychologies recognise the sociocultural and historical specificity of knowledge and, therefore, understand psychological (and medical) knowledge as being culturally and historically situated and imbued with sociocultural values (Fox et al., 2009; Ussher & Walkerdine, 2001). Second, critical psychologies recognise that, as an institution, psychology (as well as medicine and psychiatry) plays an important role in the production and dissemination of situated knowledges that, often, work to serve and maintain an unjust status quo (Fox et al., 2009; Marecack & Hare-Mustin, 2009); and, in recognising this, critical psychologies strive toward social justice (i.e., these approaches are characterised by a politics of equity). Congruent with these assumptions, and with a broader social constructionist approach, both critical psychology and critical health psychology challenge the dominant focus on the individual (and biology) as a source of abnormality, health, and illness that is common within mainstream psychology, psychiatry, and biomedicine (Barker, 2003; Crossley, 2008; Marecack & Hare-Mustin, 2009; Teo, 2009).

As with sexuality and sexual health, within this thesis I approach mental illness as socially constructed. Critical psychology provides a strong framework from which to do this. Current understandings of mental distress and illness within professional mental healthcare

[17] This is not to imply that critical psychologies necessarily or only use social constructionist approaches; but to demonstrate that these are compatible and how I have drawn on these together within this thesis.

systems in many countries, including Australia, tend to be bio-psychiatric or medical in nature. This is evidenced, for example, in the reliance on the DSM-5 (American Psychiatric Association, 2013) for classifying or understanding mental distress and in the common use of medical approaches for treating a range of diagnoses (Barker, 2003; Cromby, Harper, & Reavey, 2013; Marecack & Hare-Mustin, 2009). A critical psychological approach is sceptical of the dominant assumption that psychiatric diagnostic categories are value-free, universal facts corresponding to biological events or abnormalities that are independent of sociocultural processes. Importantly, understanding mental illness as socially constructed does not invalidate the distress that individuals experience nor suggest that psychiatry and psychology do not serve an important function in the lives of many people (Cromby et al., 2013; Priebe, 2016). Rather, a critical, social constructionist approach to psychological distress opens the door for new ways of understanding and approaching these experiences, including by acknowledging, interrogating, and challenging inequitable power relations (also see Cromby, et al., 2013).

Critical health psychology is specifically concerned with health and illness and emphasises the social, cultural, economic, political, and historical context(s) in which these are constructed, (re)negotiated, and experienced (Lyons & Chamberlain, 2006; Prilleltensky & Prilleltensky, 2003). Health and illness are therefore understood as complex social phenomena that include, but are not fully explained by or experienced as, physiological and biological processes. Within this approach, there is also a primary concern with identifying the power structures that shape our lives and define, facilitate, and produce health and illness, and challenging these when they are unjust (Crossley, 2008; Lyons & Chamberlain, 2017). As indicated by the focus on sociocultural context and power relations, critical health psychology tends to be characterised by relativist epistemologies. Researchers working

within this framework tend to be suspicious of the psychological and biomedical knowledge produced through mainstream, positivist, and reductionist approaches to health and illness. Rather than rejecting positivist approaches and knowledges, however, critical health psychology challenges the limits of these in their ability to develop nuanced understandings of health and illness as socioculturally and historically situated complex phenomena (Lyons & Chamberlain, 2017).

A critical health psychology (and critical psychology) framework is appropriate for this project because I seek to explore the ways in which mental health clinicians conceptualise sexuality and sexual health; and to examine the implications that these understandings have in how the clinicians talk about and account for their clinical practice in relation to sexuality and sexual health within mental health settings. I also critically consider how participating clinicians' perceptions of mental distress and illness are implicated or drawn on within their accounts of sexuality-related practice (illustrated most clearly in Chapter Five). Rather than aiming to 'test' whether clinicians have a particular, pre-determined understanding of sexual health, I approach the participants' conceptualisations as situated and partial, and understand their accounts as constituting social action(s) in and of themselves; which are, in turn, delimited by the discourses available to them within the broader institutional, historical, and sociocultural context, as well as their ability to resist or challenge dominant discourses.

2.3.1. A qualitative approach.

Research developed within a critical (health) psychology framework can use either or both quantitative and qualitative methods, but it is common for researchers to adopt a qualitative approach. This is because, within this framework, health and illness experiences

are understood as being constructed through social meaning-making processes. Researchers are therefore often interested in examining these processes, as well as the ways in which power shapes and makes possible particular ways of experiencing or understanding health and illness. Asking questions of health and illness in this way lends itself to the use of qualitative methods (Chamberlain & Murry, 2009; Marks, 2002). Qualitative methods are similarly well fitted with (but not mandated by) social constructionist approaches more broadly, since these tend to be concerned with examining the construction of social meaning through language and other texts (Burr, 2015a). Still, researchers working within this framework select the methods most suited to addressing their research interest and these may not always be qualitative in nature.

Indeed, critical health psychology advocates for "theoretical and methodological pluralism" (Lyons & Chamberlain, 2017, p. 541). This pluralism emphasises the need for multiple epistemologies, theories, and methodologies to open up different ways of thinking and asking questions about health and illness (Lyons & Chamberlain, 2017). This pluralism also means that critical health psychology is an inherently flexible and multidisciplinary approach. Critical researchers are able to draw on knowledge and theories that have been generated through a range of disciplinary lenses including medical anthropology, sociology of health and illness, nursing, and critical social theory (e.g., Lyons & Chamberlain, 2006). Moreover, knowledge generated within positivist or reductionist perspectives might be critiqued within a critical health psychology framework but is not necessarily rejected. This means that critical researchers can draw also on knowledge produced through these perspectives, which is common in research conducted across a range of disciplines including (mainstream) health psychology, medicine, psychiatry, and public health.

Within this thesis I have drawn on knowledge and theories generated within and across a range of disciplines and approaches, including those outlined above, articulated where relevant in Chapters Three to Seven. In doing so, I have been able to draw on theories and perspectives as they yield useful or nuanced opportunities for identifying particular analytic interests and interpreting data accordingly, rather than being restricted by firm disciplinary or theoretical boundaries (discussed further in section 2.5). This has allowed me great flexibility in asking questions of, thinking with, and analysing the data generated within this project (Jackson & Mazzei, 2012). Pluralism within qualitative research is discussed further in section 2.6.1. and in the Discussion in Chapter Eight.

2.4 Research Design

Considering the theoretical and methodological frameworks and orientations outlined in the previous sections, the main aim of this thesis was to explore the way(s) in which Australian mental health clinicians conceptualise sexuality and sexual health. Specifically, I aimed to explore how participating clinicians made sense of these concepts, both in general and within the context of mental distress or illness; and how they perceived sexuality to be relevant, or not, within their clinical practice (i.e., how they constructed or accounted for this (ir)relevance). I was also interested in attending to the social, cultural, political, and historical context in relation to this meaning-making. Mental health clinicians' understandings of sexuality and sexual health are still relatively under-researched, particularly within Australian contexts and outside of mental health nursing specifically (discussed in section 1.4.2.). An exploratory qualitative design was therefore appropriate for addressing the project aim. Similarly, in-depth interviews were selected because these allow participants to orient to and discuss issues that they perceive as being important and relevant to the phenomenon under

investigation (i.e., unlike structured interviews or surveys in which questions are more directive or pre-determined: Braun & Clarke, 2013).

Also consistent with the theoretical and methodological framework described above, I chose to analyse the data using critical thematic analysis. As a form of thematic analysis, critical thematic analysis provides a useful tool for qualitative analysis within a constructionist framework, allowing the researcher to examine both the semantic and latent content of the data (Aguinaldo, 2012; Braun and Clarke, 2006). The four analyses presented in this thesis were conducted on a single dataset in response to specific research questions relating to the overarching project aims. Critical thematic analysis as an analytic method and the process of using this to generate the four analyses presented in this thesis are discussed further in section 2.5.

In this section, I provide an overview of how the dataset was generated. Much of the information provided here is also provided in the method sections in the manuscripts included in this thesis, albeit briefly (Chapters Five to Seven).

2.4.1. Recruitment and participants.

2.4.1.1. Criteria for participation.

Participants were required to speak fluent English, be currently working directly with individuals in a mental health setting in Australia (i.e., not in a research- or teaching- only role), and hold or be close to completing full qualification within their profession. Accordingly, psychologists were required to hold general registration or be endorsed. Psychologists with general registration have completed the relevant qualifications as approved by the Psychology Board of Australia and are able to legally practice as a psychologist in Australia; and endorsement indicates that a psychologist has completed

additional qualifications in a recognised area of practice[18]. Psychiatrists were required to be Fellows of the Royal Australian and New Zealand College of Psychiatry (RANZCP; i.e., they had completed all of their relevant training). Mental health nurses were required to be 'specialist mental health nurses' as recognised by the Australian College of Mental Health Nursing (ACMHN); these are registered nurses who have usually completed additional postgraduate study in mental health nursing.

Participants were also required to be currently working in metropolitan areas as defined by government regions in each state. For example, the Adelaide metropolitan area is defined as the Eastern, Northern, Southern, and Western Adelaide government regions, and excludes the Greater Adelaide Area and Country regions (Department of Planning, Transport and Infrastructure, 2015). This was because there are potentially important differences between metropolitan and non-metropolitan populations in relation to the experience of mental distress, health service availability and accessibility, and the skills and competencies required of mental health clinicians (e.g., Vines, 2011). Accordingly, the perceptions of clinicians who are working in non-metropolitan areas may be different to those working in metropolitan centres. Eliciting a detailed understanding of the perceptions of psychologists, psychiatrists, and mental health nurses both inside and outside metropolitan areas was thus beyond the scope of the project.

2.4.1.2. Recruitment.

Several purposive sampling strategies were employed in this project, including convenience sampling, snowballing, and stratification sampling. Participants were recruited

[18] Clinical, health, and forensic psychology are three of the nine areas of practice endorsement (APS, 2020b). Clinical psychology is the most common endorsement. Clinical psychologists are specialists in assessing, diagnosing, and treating defined "mental illnesses and psychological problems" (APS, 2020a) and, in this way, clinical psychology is aligned with psychiatry.

via advertisements (Appendix A) shared through the Australian Psychological Society (APS), RANZCP, ACMHN, and the Health Psychology Forum (online) based in South Australia. Two of the project supervisors, Professor Anna Chur-Hansen and Dr Carole Khaw, also circulated an invitation to participate through their professional networks (ACH is a health psychologist, CK is a sexual health physician: Appendix B). Participants were asked to pass on information about the study to their colleagues. Clinicians who were interested in participating then contacted me directly to receive more information about the project. The supervisors, including the two who contributed to recruitment, do not know who participated in the project and this was intended to further protect the anonymity of participants, especially those who were Adelaide-based. This is because Adelaide is a relatively small city where many clinicians are known to one another.

Purposive stratified sampling was employed to achieve variation in the age and gender[19] of participants across profession groups. This stratified sampling was intended to ensure a diversity of perception across the sample (including within profession groups), particularly in relation to primary, secondary, and tertiary socialisation. I considered that recruiting participants across a range of ages would contribute to producing a sample of participants who had been clinically trained and had experience in working across a range of time periods[20] and therefore across a range of dominant approaches to mental distress and sexuality (i.e., pre- and post- de-institutionalisation: e.g., Barker, 2003). Moreover, participants across different age groups would likely have experienced different generational values and approaches toward sex, sexuality, and sexual health for example with regard to the

[19] We attempted to recruit both men and women, but no specific efforts were made to recruit clinicians who identify as transgender or non-binary.
[20] Of course, age is an imperfect proxy for years' clinical experience and therefore time since tertiary education.

criminalisation and medicalisation of homosexuality; the HIV/AIDs epidemic during the 1980's and consequent public health 'safe sex' campaigns; the advent of Sildenafil, or Viagra; and more recent visibility and legitimacy of gender and sexuality diversity in political and social contexts (e.g., Perales, Lersch, & Baxter, 2017; Tiefer, 2006; Weeks, 2010).

I initially aimed to recruit at least one woman and one man for each professional group who was younger than 30-years old, and one of each who was older than 40-years old. These criteria were met passively among participating mental health nurses but some active purposive sampling via targeted invitations (passed on by ACH and CK) was required among the psychologist and psychiatrist samples. No psychiatrist younger than 30-years was able to be recruited, likely because of the length of time it takes to train in medicine and become a psychiatrist (a minimum of twelve years: The Royal Australian and New Zealand College of Psychiatrists, 2017). We also aimed to recruit participants who were working across a range of settings, including in private and public sector, and this criterion was met passively with no requirement for active sampling.

2.4.1.3. Participants.

Participants were eight psychologists, six psychiatrists, and eight mental health nurses working in four metropolitan Australian cities (Adelaide, Canberra, Melbourne, and Sydney). Most participants were of European descent[21], and all had completed their professional education and training in Australia or New Zealand. Across all three groups, participants ranged in age from 25–75 years, and in qualified professional experience from 2 months to 40

[21] Most participants identified themselves as being of European descent (usually "Caucasian"), but a few identified themselves differently. While it is useful to note that most of the participants were of European descent (i.e., white), we do not provide further information about participants' ethnic background because this will reduce anonymity.

years. When asked how they identify their gender, all participants reported either ‘woman’ (twelve) or ‘man’ (ten) and none specified trans- or non-binary gender identities. Participants were working with a range of individuals and across various mental health settings including private practice, community mental health, emergency departments, and psychiatric inpatient facilities (acute, semi-acute or short-stay, and semi-forensic settings).

Psychologists (4 women, 4 men) ranged in age from 27–52 years and in professional experience from 18 months to 25 years. Five of the psychologists were endorsed clinical psychologists; one was an endorsed forensic psychologist currently studying their Master of Psychology (clinical); one was a health psychology registrar (holding general registration and currently working toward endorsement); and one was a registered psychologist. Many (but not all) of the psychologists worked in private practice, and most provided some or all government-subsidised services regardless of sector (public or private). Accordingly, most psychologist participants reported working with individuals from a lower socioeconomic background, and some also worked with individuals from mid and higher socioeconomic backgrounds.

All the psychiatrists (3 women, 3 men) were Fellows of the College (i.e., fully qualified). They ranged in age from 32–75 years and in qualified professional experience from 2 months to 35 years. Most of the psychiatrists worked in both public and private roles, however most psychiatrists reported working primarily in the public sector and with individuals from lower socioeconomic backgrounds.

Mental health nurses (5 women, 3 men) ranged in age from 25–65 years and in professional experience from 18 months to 40 years. Seven of the eight nurses were specialist mental health nurses and one nurse was very near completion of their graduate diploma but

was not yet recognised by ACMHN as being specialised in mental health nursing. This nurse was very keen to participate, and review of their transcribed interview indicated that their perceptions were not notably different from ACMHN-recognised mental health nurse participants, so their data were included in the dataset. All mental health nurse participants were working in the public sector and with individuals from lower socioeconomic backgrounds, though some had previously worked in the private sector.

We did not ask participants to report their sexual orientation. This pragmatic decision was two-fold. First, we were interested primarily in participants' perceptions of sexuality (which can include sexual orientation) in their work and not their personal lives, regardless of how intertwined we believe these to be (see section 1.4.2.). Second, we were concerned that recruiting people to talk about a topic that is often considered sensitive (sexuality and sexual health) would be made more challenging by also asking them to also talk about their personal lives or experiences specifically. Accordingly, we decided not to ask participants to report their sexual identity or to discuss their personal experiences around sexuality and sexual health; but such discussions were welcome in the interview if initiated by participants. Two of the men who participated openly identified as "gay" and one woman specifically identified herself as "heterosexual". The decision not to ask about participants' sexual identity within interviews that necessarily focussed on their perceptions of sexuality more broadly may have shaped the data generated in those interviews, and this is explored in more detail elsewhere in the thesis (section 2.6.3.1. and Chapter Three).

2.4.2. Generating the data.

As per the process outlined in the ethics approval, clinicians who were interested in participating in the project contacted me by email. I then provided an information sheet that

outlined the nature, purpose, and possible risks or benefits of the study (Appendix C) and answered any other questions that they had. Clinicians who wanted to continue with participation were then emailed a copy of the consent and complaints forms (Appendices D, E) and we scheduled the interview.

In-depth interviews were conducted between January and December 2016 and lasted an average of 61 minutes (44–89 minutes). Eighteen interviews were conducted face-to-face at the participants' workplace or the University of Adelaide and the rest were by telephone, depending on participants' preference and location. At the beginning of each interview, I explained the aims and processes of the interview and the research project as outlined in the participant information sheet and went through the consenting procedure to gain written informed consent. Participants who were interviewed by telephone signed and returned the consent form prior to the interview and, as they had already consented to having the interview audio-recorded, I went through the consenting procedure and re-confirmed their consent verbally on tape. All participants consented to have their interviews audio-recorded.

The interviews were open-ended and directed primarily by participants' accounts, using probing to encourage participants to elaborate on relevant details or ideas in order to generate rich and detailed data. An interview guide was developed based on the broad aims of the project and by drawing on the existing literature exploring sexuality and sexual health topics within health and mental health contexts, particularly within an Australian context (e.g., Quinn, 2013). This was updated during data generation when new topics of interest were raised by participants. The interview guide was not used as a compulsory script or schedule but, rather, as an aide-memoire to ensure that all topics of interest were discussed (Appendix F). In particular, I aimed to always elicit participants' understandings of the terms

‘sexuality’ and ‘sexual health’ and their perceptions of addressing these in their work, including when and why these might be considered (ir)relevant in their practice. By the fourth interview, and through audit trailing and discussion with the primary supervisor (ACH), I noticed that participants’ understandings of sexuality and sexual health within their work were somewhat informed by the way that they constructed mental health and illness (explicated in Chapter Five). The interview guide was updated accordingly to also include a (brief) elicitation of participants’ conceptualisations of mental health and illness.

Although I endeavoured to explain the interview process to participants before we began, some participants found the open-ended, participant-led structure of these difficult to navigate. This seemed to be an issue particularly for psychiatrist participants, the majority of whom were interviewed in the second half of data collection due to difficulties in recruiting. Some nurse and psychologist participants also appeared to find the research interview process unfamiliar. To address this, I began to include a specific preamble during the consenting procedure that oriented participants to the process of the research interview as a conversation in which there are no ‘wrong’ responses or accounts (Appendix G: Braun & Clarke, 2013). This also had the benefit of helping to build rapport with some participants, as we were able to reflect together on how strange or jarring a research interview can be compared with usual or everyday conversation, for example because the interview is a site of unusually deep reflection that tends to be reasonably one-sided.

Demographic information about participants was collected verbally on the interview recording (but their names were never audio-recorded). Information about participants’ professional training and role was collected at the beginning of the interview and I used this as an opportunity to build rapport and move slowly into the interview. More ‘sensitive’

information including age, self-identified ethnicity, religion, and gender were all collected at the end of the interview.

Although the interviews were in-depth and guided primarily by participants, I recognise the interview as a site of power (power relations and how these shape the interview are discussed further throughout section 2.6). Particularly as the subject of the interviews – sex, sexuality, and sexual health – is 'taboo' and can be uncomfortable or embarrassing to discuss (e.g., Kneale et al., 2019; Weeks, 2010), I aimed to ensure that participants felt as comfortable with and in control of the conversation as possible. I explained carefully to participants their ability to choose not to respond questions or prompts, to end any specific line of conversation within the interview, and to end the interview at any time without needing to inform me why. I did not ask participants questions about their personal experiences or understandings in relation to sexuality, sexual expression, relationships, and intimacy; but I was open to hearing about and discussing these if the participant chose to raise it. Towards the end of the interviews but before collecting final demographic information, I always flagged that I had no more topics to raise and invited the participant to add, discuss, or revisit anything before we closed the interview. Signalling to the participant in this way that the interview might be coming to an end shifts the power to close the interview from the researcher to the participant, allowing them to decide if the interview should be continued or closed (Oakley, 2016).

I wrote reflective summaries within 24-hours of completing each interview. These summaries formed part of the project's audit trail and were recorded on a structured record sheet that I developed for this purpose (Appendix H), based on existing field research literature (e.g., Burgess, 2002). In writing these summaries, I aimed to contextualise the

interview data by reflecting on the interview encounter, including any difficulties in the interaction, and to reflect on the content of each interview in relation to those previously completed. Only transcribed data were used in the analyses presented in this thesis; however, I drew directly on notes from the audit trail in developing a manuscript that reflexively explores methodological and ethical issues in relation to (non)disclosure of sexuality within the interviews (Chapter Three; also discussed in section 2.6.3.).

Interviews were audio-recorded and transcribed orthographically to include turn-taking, interruptions, and overlapping speech; abbreviations and vernacular speech; non-verbal utterances (e.g., 'um', 'ah', 'er'), repetitions, and cut-off speech; emphasis on words or parts of words; reported speech; and pauses (untimed, but indicated if longer than approximately three seconds: Braun & Clarke, 2006, 2013). Transcripts were anonymised and de-identified. Participants were given the option of receiving a copy of their de-identified transcript to review and approve, and many chose to do so (five of eight psychologists; four of six psychiatrists; and seven of eight nurses). Two participants requested further de-identification and three provided clarifying remarks about elements of the transcript which were included, with consent, in the dataset. Where scheduling permitted, I transcribed each interview before conducting the next. During transcription, which marked the initiation of familiarisation for analysis (discussed in the next section) I noted my impression of the data and preliminary analytic ideas and codes.

Participants from all three professions were recruited and interviewed concomitantly and interviewing continued within each group until my supervisors and I decided together that data 'saturation' had been reached. That is, until no 'new' experiences or ideas were being discussed by participants and no new preliminary codes were being generated, both

within and across profession groups. This decision was based on both the interview summaries and the initial notes made during transcription. This judgement regarding saturation, or completion of data collection, was a pragmatic one that referred mainly to the semantic level of the data and is by no means a claim to have collected an exhaustive representation of mental health clinicians' understandings of sexuality and sexual health in their work (see Braun & Clarke, 2006). Moreover, the decision to cease data collection was made on the stipulation that more data would be collected if it was deemed necessary during data analysis, for example if required for theme development; however, as all analyses were conducted using the full dataset (i.e., a sample of n=22), this was not necessary and no more data were collected.

2.5 Data Analysis

Early in the project, I had planned to conduct three discrete studies by analysing the datasets for each of the three profession groups separately. As I began conducting and transcribing the interviews, however, it became clear that there were no neat discipline-specific boundaries in how the participants perceived or oriented toward and away from sexuality within their work. Rather, participants across disciplines drew on a variety of conceptualisations and ways of making meaning in relation to sexuality, sexual health, and mental distress. Moreover, there were multiple and competing questions that could be asked of the data, and multiple and competing ways of thinking with the data (Jackson & Mazzei, 2012). We therefore decided that I would conduct multiple analyses on the entire dataset rather than singular analyses on three smaller, discipline-specific datasets. This allowed me to ask different questions of these data as a whole set, drawing on different theoretical perspectives to approach or interpret the analyses as appropriate. While these analyses were somewhat iterative and, having been generated within one project, do speak to one another,

they are also independent of one another (i.e., having always been developed from raw data), as explicated in section 2.5.2.

Four analyses are presented in this thesis that were each generated using critical thematic analysis (Chapters Four to Seven). This analytic method was selected because it is epistemologically and theoretically flexible, and it can be conducted within a constructionist framework (Braun & Clarke, 2006). Consistent with the theoretical and methodological frameworks described earlier, I was interested in exploring what participants had to say as well as the frameworks or discourses on which they drew to interpret, account for, and make meaningful their experiences and perceptions regarding sexuality in mental health settings. By conducting thematic analyses within a constructionist framework, or *critical* thematic analyses (Braun & Clarke, 2006), I was able orient to both what participants said (semantic content) and the underlying ideas and assumptions that shaped their talk (latent content) to examine how participants constructed meaning in relation to sexuality and sexual health within mental health settings. In the two subsections that follow, I describe this analytic process broadly and then discuss how I applied this in generating the results presented in Chapters Four to Seven.

2.5.1. Critical thematic analysis.

The process of generating the results presented in this thesis was iterative in and of itself, reflecting my own learning process. When I began, I did not know how to conduct a thematic analysis and learned by trial-and-error, with steering from my primary supervisor. I made several false starts as I attempted to code and then develop themes. For example I initially tried unsuccessfully (and unintentionally) to 'force' data into a preconceived thematic map, generating 'bucket themes' in relation to biological, psychological, and social

aspects of sexual health rather than generating codes and themes that captured something meaningful about the data in relation to the research question(s) (Braun & Clarke, 2016; Terry, Hayfield, Clarke, & Braun, 2017). I also moved through several methods for managing the analysis, particularly the coding process, from working by hand with pens and printed copies of the transcripts, to using comment and highlight tools on Microsoft Word, and finally to using N*Vivo (QSR International, 2018) to manage the coding and early theme development process before developing themes further using Microsoft Word. Over time, I developed the skills required to conduct rigorous and reflexive thematic analyses, as guided by Braun & Clarke's (2006, 2013) iterative six-step process: Familiarisation, coding, generating themes, reviewing and defining themes, and 'writing up' or producing the report. These steps, as I applied them in each analysis, are described below.

Immersion in and familiarisation with the data begins during the process of transcribing the audio-recordings. I maintained an audit trail (or 'memos') throughout transcription to note ideas, potential codes or patterns, and features of the data that appeared relevant or interesting within the context of the overarching research aims and questions (Terry et al., 2017). I also noted thoughts and reactions or emotions that I had in response to the data and actively reflected on these in relation to how they might shape the analysis. When transcription of the entire dataset was complete then I engaged in 'repeated reading' of the transcripts to begin actively generating meaning and patterns across the data that would form the basis of the codes (Braun & Clarke, 2006). True to the iterative nature of thematic analysis, I returned to the raw transcripts to re-immerse myself in the data at several points throughout the process of generating analyses (e.g., including when shifting my attention to a different research question).

Coding assists the researcher to reduce and organise the data to produce meaningful, systematic observations (Terry et al., 2017). Coding was 'open' and inductive, staying close to the data but attending to both semantic and latent properties where appropriate (Braun & Clarke, 2006). Code generation was also informed, but not restricted or pre-determined, by the audit trail notes made during the familiarisation process. Although the researcher must move onto theme development at some point, coding is flexible and codes are often modified further or clarified later as themes are generated and defined and the research question is sharpened (Braun & Clarke, 2006, p. 87). For example, throughout the analyses, but after the formal coding phase(s), new codes were occasionally generated, some codes were broken down to reduce complexity, and others were grouped together to reduce redundancy at the level of codes.

Themes, which are actively generated by the researcher from codes (i.e., not 'found' in or 'emerging from' the data), capture patterning across the entire dataset in relation to overarching and specific research questions (Braun & Clarke, 2016; Terry et al., 2017). Provisional themes are developed through a process of "combining, clustering or collapsing codes together into bigger or meaningful patterns" (Terry et al., 2017, p. 27). Some themes are generated by 'promoting' codes to themes, where the code already captured some salient patterning in relation to the analytic focus, while others are generated by grouping several codes around a central concept (Braun & Clarke, 2006; Terry et al., 2017). Some codes may be discarded at this point, while others are modified or created (as discussed above). Thematic maps may be used at this stage to visualise the patterns being developed across the dataset and the potential relations between provisional themes, including different levels of themes (Braun & Clarke, 2013; Terry et al., 2017). Research questions may also be sharpened throughout the process of theme development (Terry et al., 2017). Indeed, the specific

research questions in some of the analyses presented in this thesis were honed throughout the respective analysis and only settled during review of final themes.

Reviewing and defining (provisional) themes is an important and iterative phase of the analysis process. Provisional themes are reviewed to ensure that they work well together (i.e., they are distinct, not overlapping); that they sufficiently capture or narrate the patterned meaning that is collated within the code or codes that built each theme (i.e., coherence against the codes); and that the provisional themes, and the analysis, are similarly coherent against the dataset as a whole (Braun & Clarke, 2006; Terry et al., 2017). The researcher must also ensure that the analysis answers the research question. At this stage the research question may be modified slightly to better fit the analysis rather than re-working the analysis to fit question (Terry et al., 2017).

In naming and defining the final themes, the researcher develops an analytic narrative. The key foci here are "clarity, cohesion, precision and quality" of the analysis and ensuring that each theme sufficiently "capture[s] richness and diversity around [a] core meaning" (Terry et al., 2017, p. 31). Themes that are too complex might be further developed and themes that are too thin may be developed, discarded, or demoted to a sub-theme. When the themes have been finalised, the analysis should sit together to form a coherent 'answer' to, or story in relation to, a specific research question that is ready to be 'written up'.

Producing the report is a final, distinct phase in which the researcher refines the analysis by "weav[ing] together data, analysis and connections to scholarly (and other) literature into a singular output that answers their research question(s)" (Terry et al., 2017, p. 32). At each stage of the analysis, but particularly during the later stages, including theme development and definition and writing up, the researcher engages in interpretation and

builds an argument (or story) about the data in relation to the research question (Braun & Clarke, 2006).

2.5.2. Generating the analyses.

The results presented in this thesis represent four separate analyses, each developed through focussed and iterative engagement with the whole dataset in relation to a specific research question. That is, these analyses do not represent four overarching themes generated from an initial analysis and explicated across four chapters or manuscripts. Although the entire dataset was initially coded (inductively) and many of these codes informed or contributed to various analyses, I always returned to the raw data and 'step one' in order to generate analyses in relation to specific research questions. So, in developing each analysis I did draw on relevant preliminary codes, but I also generated new codes in relation to the new research question, modified and clarified existing codes, and discarded codes that were not relevant to the specific analytic interest.

While each of the analyses are informed by a broadly social constructionist approach within a critical health psychology framework, the extent to which they are descriptive and focus more on semantic aspects of the data, or rather interpretive and examine latent aspects of the data, varies according to the specific research question in relation to which the analysis was generated. The analysis presented in Chapter Four provides an in-depth exploration and interpretation of participants' understandings (and construction) of sexuality and sexual health, and this is the most descriptive analysis presented in this thesis. Although this is interpretative and both semantic and latent aspects of the data were attended to during analysis, the results are largely focussed on semantic features of the data. In contrast to this, the analysis presented in Chapter Five was developed through a specific analytic interest in

the ways that participants perceived sexuality as being relevant within the mental health setting. Since participants mostly perceived sexuality and sexual expression as being relevant when it was also perceived as dangerous, this analysis came to examine the ways in which participants constructed this danger by drawing on responsibilising neoliberal health discourses and perceived loss of autonomy in the context of mental illness experiences.

The two manuscripts presented in Chapters Six and Seven present analyses that are both latent and inductive. These analyses were initially developed together in relation to a broad analytic interest in the ways in which sexuality was silenced within participants' practice and the settings where they worked, and particularly in how participants accounted for this silence. Three overarching themes were generated in relation to this broad interest. As the analysis was developed and research question(s) refined, I decided to develop the relevant overarching themes in relation to two, more specific research questions. For one analysis (presented in Chapter Six), the focus was now specifically on how participants accounted for sexuality-related silence within their own and their colleagues' practice. This research question was directly relevant to (or answered by) two of the three initial overarching themes, so these were finalised and written up accordingly. The second analysis (presented in Chapter Seven) involved further development of the third initial overarching theme to explore how participating mental health clinicians implicated the wider institutional context in which they learn and work in their accounts of sexuality-related silence in mental health practice and settings. In developing this analysis, I returned to the raw data with this new analytic focus in mind and generated some new codes as well as modifying and discarding some existing codes in order to fully develop this analysis in relation to the new focus.

2.6 Quality and Ethics in Qualitative Research

There is a need to discuss and evaluate the quality and rigour of qualitative research across all paradigms, but this is a complicated and divisive topic (Chamberlain, 2000; Yardley, 2000). Notions of validity and reliability, and methods for evaluating quality more generally, within quantitative (and often realist) paradigms do not translate well to qualitative research, particularly when that qualitative research is underpinned by relativist epistemologies (and ontologies: Yardley, 2000). Nonetheless, there is an established need for broad criteria relating to rigour, validity, and quality within and across qualitative research approaches. Indeed, researchers need to demonstrate "care" and "thoroughness" in their work (Chamberlain, 2000, p. 291).

Some researchers have suggested useful principles for evaluating or conceptualising quality and rigour in qualitative research across paradigms, including research that is driven by relativist epistemologies more broadly. In this section, I draw on Yardley's (2000) and, to a lesser extent, Tracy's (2010) discussions of quality in relation to qualitative research. The criteria or principles that these authors suggest map strongly onto both the theoretical and methodological frameworks discussed in the first sections of this chapter. Moreover, these criteria are necessarily broad and highly flexible, and I discuss these specifically within the context of choices and processes within my own project in the following sub-section. Both ethical and reflexive practices are entangled with many of the processes required for ensuring high quality within qualitative research more generally. Similarly, ethical and reflexive practices are not neatly separable; reflexivity has tended to be taken up as a tool for embedding ethics in research practice (Guillemin & Gillam, 2004). For simplicity, however, ethical concerns and reflexive practice in qualitative research are discussed separately in the succeeding sub-sections.

2.6.1. Doing high quality, rigorous qualitative research.

Yardley (2000) has proposed four broad principles for quality that are flexible and can be achieved in different ways across various paradigms that use qualitative research, including within a critical and social constructionist paradigm. These principles are: Sensitivity to context; commitment and rigour; transparency and coherence; and impact and importance. Tracy (2010) has similarly outlined eight, more defined criteria for quality in qualitative research across paradigms. These are closely aligned with the broader criteria outlined by Yardley (2000) and so, for simplicity, I explicitly draw on Tracey's (2008) criteria only when they extend or deepen those explicated by Yardley.

Sensitivity to context refers to the researcher's grounding and immersion in the theories and "intellectual history" of, or relevant to, the phenomena under investigation (Yardley, 2000, p. 220). The researcher's ability to orient to and challenge an unjust status quo or taken for granted assumptions surrounding phenomena are both dependent on and demonstrative of their sensitivity to context. This principle is somewhat foundational for doing high quality qualitative research since, without it, research is unlikely to achieve many other criteria related to quality including rigour, coherence, or impact (discussed below). Immersion in and an appreciation of the relevant literature and theoretical approach(es) to sexuality and sexual health, including within the context of mental distress and illness, is evidenced in Chapter One, previous sections within this chapter (2.2, 2.3), and in the introduction sections of the manuscripts included in the thesis (Chapters Five to Seven).

Sensitivity to context also requires an awareness of the relevant sociocultural context and ways in which this shapes the phenomena under investigation (Yardley, 2000). Accordingly, this requires or can be demonstrated through an orientation to the research

interview as interaction (i.e., where the researcher/interviewer are not 'neutral'). In this way, although not necessarily *unique* to qualitative research or research underpinned by relativist epistemologies, the criteria for sensitivity to context is a *necessary* requirement in conducting research that is grounded in a social constructionist approach. This positions the researcher as necessarily active in the research process and requires that they be actively reflexive in relation to this, for example by demonstrating awareness of the sociocultural context and assumptions that they bring to their work. Reflexivity, including awareness and critical reflection of the researcher's own positioning, is also considered to be a feature of critical psychologies, including critical health psychology, by many scholars who position themselves within these subdisciplines (e.g., Chamberlain, 2015; Crossley, 2008; Lee, 2006; Ussher & Walkerdine, 2001). Reflexivity within the current project is discussed in detail in section 2.6.3. and in Chapter Three.

Commitment and rigour are about thorough engagement with the topic or phenomenon under investigation and the methods used to examine it. This principle is most related to the common expectation for all research, including within realist paradigms, of "thoroughness" (Yardley, 2000, p. 221). Rigour is achieved in qualitative research by making choices throughout the research process that are most appropriate in relation to the research aims and questions; for example, by selecting participants, collecting data (and enough of it), and applying methods of analysis that best fit the research goals, methodology, and the broader context (Tracy, 2010). Rigour was achieved in this project through a range of choices and processes discussed in the previous sections of this chapter, including by collecting appropriate data from a range of participants via in-depth interviews (section 2.4); collecting enough data, as determined by *pragmatic* saturation (section 2.4); and by selecting critical

thematic analysis as the method of analysis to allow a flexible exploration of both semantic and latent meaning within and across the data (section 2.5).

In relation to data analysis, rigour also refers to "completeness of the interpretation" (Yardley, 20002, p. 222). Other scholars have also oriented to this concern, for example Chamberlain (2000) has discussed the problematic practice within qualitative health research of producing description at the expense of interpretation, whereby researchers simply describe what participants have said but do not offer an interpretation of, or insight into, their experiences. Within thematic analysis, completeness of interpretation means that the analysis has been fully developed (Terry et al., 2017). I endeavoured to achieve thorough interpretation within analyses by keeping an ongoing audit trail where I recorded ideas and decisions that shaped the analysis; and through repeated discussions with my supervision panel, including having my supervisors (ACH and CK) check my coding and theme development across analyses. This 'checking' was not intended to achieve some objective notion of reliability but, rather, to assist me in reflecting on the way that I (as novice) generated the analyses, the decisions I made, and what I may have been overlooking (Clarke et al., 2019).

Qualitative research must also be coherent and transparent, and this is achieved in several ways. Qualitative research that is rigorous, particularly in terms of the fit between theoretical approach, methodology, research aims and question(s), and method, will usually be coherent (Yardley, 2000). Coherent research also has a strong analytic narrative that is persuasive or resonates with the reader (Tracy, 2010; Yardley, 2000). Persuasiveness is achieved partly through evidence of completeness of interpretation, discussed above, and through being transparent about the perspectives, choices, and interpretations that have

culminated in the knowledge claims being made by the researcher. Providing enough detail when reporting method, providing evidence of the analysis (e.g., illustrative extracts), and keeping a detailed audit trail also contribute to transparency (Braun & Clarke, 2013; Yardley, 2000). I have attended to the issues of coherence and particularly transparency in conducting and disseminating the research presented in this thesis by endeavouring to include sufficiently detailed 'methods' sections in manuscripts for publication (Chapters Five to Seven). The method sections in manuscripts published in academic journals are often overly truncated due to limitations on space and the trade-off made for depth or detail in other sections, and due to editorial preferences; a challenge that has been discussed elsewhere (e.g., Wigginton, Gibson, & Scholz, 2018). I have explored means of overcoming this limitation, which reduces the opportunity for sufficient transparency, for example by providing an extended account of methodological concerns and processes in a supplemental document alongside the published manuscript in Chapter Five (Appendix I).

This need for persuasiveness, which is related to both coherence and rigour, has also been conceptualised as "credibility" or "trustworthiness", and this can be established through a number of processes including triangulation or crystallisation (Tracy, 2010, p. 842). Triangulation refers to the practice of drawing on multiple sources of data (which may or may not be collected through different methods) in asking questions of phenomena and "explor[ing] convergences, complementarities, and dissonances" in the narratives produced through analysis (Treharne & Riggs, 2015, p. 64 also see Tracy, 2010). The research presented in this thesis is an example of triangulated sources of data because I generated data across three distinct groups of mental health professionals (albeit via the same method of data generation).

Although triangulation is often assumed to emphasise realist epistemological approaches, it is not constrained to realist qualitative research nor does it (necessarily) intend to identify a singular, objective truth (Treharne & Riggs, 2015). Nonetheless, a similar approach that is grounded specifically in a poststructuralist perspective has been developed: (Multi-genre) crystallisation encourages researchers to take up multiple sources of data, methods, and forms of analysis to "open up a more complex, in-depth, but still thoroughly partial, understanding" of the phenomenon under examination (Tracy, 2010, p. 844. Also see Ellingson, 2011). To some extent, both triangulation and crystallisation are variants of a broader, more amorphous concept of pluralism in qualitative research (e.g., see Frost & Nolas, 2011). Pluralistic research refers to the process of combining multiple approaches in relation to theory, methodology, or method (or some combination of these) within the context of one study or project, with the aim of amplifying meaning (Frost & Nolas, 2011; Willig, 2017). By engaging multiple theoretical or interpretive lenses within one project for example, researchers can generate a layered analysis (or analyses) that acknowledges tensions between readings of the data rather than attempting to produce one coherent (and 'most valid') story or truth claim (Frost & Nolas, 2011; Willig, 2017). This resonates with the pluralistic, flexible approach within social constructionist and critical health psychology frameworks toward theory and method(ologie)s, and the opportunities that these frameworks present for knowledge production, as discussed previously (see sections 2.2, 2.3.1). While the research presented in this thesis is not an explicit attempt to engage a specifically pluralistic (or crystallised) approach, I do draw on various theoretical perspectives to produce multiple interpretations of the same data. Moreover, while the analyses presented are all broadly grounded in a critical, social constructionist perspective, their analytic foci shift between more descriptive and more latent interpretations (or, "emphatic" and "suspicious": Willig,

2017, p. 276). I will return to this issue of pluralism within this thesis, and potential advantages of this, in Chapter Eight.

Finally, quality qualitative research must have impact and importance (Yardley, 2000); it must add something and be of use. As with the other principles for quality, what counts as impact or utility is flexible and broad. Many researchers have discussed the notion that qualitative research of high quality should have impact, for example by contributing to positive change in clinical practice or broader social understandings in relation to the phenomenon of interest (Chamberlain, 2000). There are several thematic categories for the ways in which research may have impact or be useful, including theoretical, educational or practical, and sociocultural (Chamberlain, 2000; Tracy, 2010; Yardley, 2000). The impact or significance of the research presented in this thesis is explicated in the discussion sections of published and prepared manuscripts (Chapters Three and Five to Seven) and in the discussion chapter (Chapter Eight).

2.6.2. Doing ethical research.

All research must be ethical but what it means to conduct ethical research within a critical and social constructionist paradigm often requires "nuanced and complex" consideration (Macleod, Marx, Mnyaka, & Treharne, 2018, p. 2). All research carried out within psychology and the social sciences is required to receive ethical approval from an ethics committee at the researchers' academic institution (and sometimes other institutions); but these procedural ethics are not the whole picture, particularly in relation to qualitative or critical research (Guillemin & Gillam, 2004). Indeed, the social constructionist principle of challenging the status quo and the overarching concern with "context, power, and social justice" within critical health psychology (Lyons & Chamberlain, 2017, p. 536), both

discussed previously, are indicative of an ethics that goes beyond, for example, an aim to maintain privacy and 'do no harm'.

Process ethics are an important dimension of ethical research practice that extend beyond procedural ethical checklists to the ways in which research is conducted in and beyond the field. In their initial distinction between procedural and process ethics, Guillemin and Gillam (2004) focussed on "microethical dimension[s]" of the researcher-participant interaction and the way in which (qualitative) researchers negotiate unanticipated ethical dilemmas in the field (p. 270). Process ethics extend beyond a concern with research practice directly in the field (i.e., relational ethics: Tracy, 2010; Yardley, 2000), however, incorporating broader "macro" ethical concerns (Brinkmann & Kvale, 2012, p. 260) including those related to leaving the field, interpreting the data, and producing and disseminating knowledge (i.e., exiting ethics). Below, I discuss procedural, relational, and exiting ethical concerns as they are relevant within this thesis.

2.6.2.1. Procedural ethics.

Procedural ethics refers to the ethical principles and actions set out by institutions and ethics committees as a requirement for all research activities, including issues related to informed consent, safety, and privacy (Tracy, 2010). The research presented in this thesis was approved as a low-risk project by the School of Psychology Human Research Ethics Subcommittee at the University of Adelaide (reference:15/107). All participants gave written informed consent and were provided with the information necessary to make an independent complaint about the research, as discussed earlier (see section 2.4.2.); though no complaints were made. This study was expected to cause no harm or distress to participants but a procedure to respond to participant distress was arranged (this was never required to be used).

Similarly, a check-in procedure to maintain my own safety during interviews was devised and followed.

Confidentiality and anonymity were of particular concern because the level of detail collected through qualitative interview studies is very high, increasing the risk that a participant's identity can be deduced from the interview transcript or from information and illustrative data included when disseminating the research (Goodwin, 2006; Tracy, 2010). A number of measures were taken to address privacy including de-identification and anonymisation of all data (e.g., using pseudonyms, removing names of workplaces) and giving participants the opportunity to review and approve final de-identified interview transcripts, and therefore to request further de-identification (Goodwin, 2006). Ensuring the anonymity of participants within the thesis and wider dissemination of the research was particularly important because, as already noted, many of the participants were from Adelaide which is a relatively small city where mental health clinicians are often known to each other. Accordingly, I have refrained from specifying individual participants' age, location, work setting(s), and sub-speciality, except when required for analytical clarity. I also removed idiosyncratic utterances from illustrative extracts that could be identifiable, but which did not change the meaning of the extracts. Two of the supervisors are practicing clinicians in Adelaide and so, while they were clearly aware of who within their networks they invited to participate (see section 2.4.1.2.), they do not know who accepted or declined these invitations. More broadly, they do not know any participants' identities and only read de-identified transcripts. These measures were outlined clearly to participants on the information sheet and during the consenting procedure.

2.6.2.2. Relational ethics.

The way in which researchers approach the interview, or the field, and engage with participants are saturated with ethical concerns not often acknowledged or well-articulated within procedural ethical checklists (Guillemin & Gillam, 2004; Tracy, 2010). Relational ethical concerns seem to approach a feminist ethic of care (e.g., Gergen, 2017), whereby researchers approach participant interactions as a relationship that must be respected and cared for, rather than as a transaction or 'taking' (of data) from passive participants.

Qualitative research interviews can be understood as a site of dynamic and evolving negotiations of power in which both participant and researcher are actively engaged in the generation of data, or stories, and "neither [are] without power at any point in the interview process" (Limerick, Burgess-Limerick, & Grace,1996, p. 458). This contrasts with a more traditional, 'masculinist' approach in which the interview is understood as an exploitative relationship characterised by static asymmetrical power relations in favour of the researcher (Limerick et al., 1996; Oakley, 2016). Participants are afforded power throughout the interview process, including in their initial choice to volunteer and their ability to withdraw at any time; in selecting the time and location of the interview and, often, in directing the negotiation of seating arrangements (especially if the interview location is in a space familiar to them, such as a workplace); and in taking charge of the agenda (Limerick et al., 1996). Ultimately, the participant always has the power to share or not share the stories in which the researcher is interested; the stories that the researcher needs to carry out their research. Accordingly, Limerick and colleagues argue that the interview should be understood as "a *gift* of time, of text, of understanding" from the participant to the researcher (p. 458, emphasis in original). This understanding explicitly acknowledges participants' power and agency within the interview.

I entered the field – or, the interviews – with the intention to work respectfully with participants to develop an understanding of (and not simply 'collect' from them) their perceptions or meaning-making of sexuality and sexual health and their experiences of navigating these within their work. At the beginning of each interview, I specifically and explicitly situated myself as an interested and respectful listener, and participants as experts of their own experiences (see section 2.4.2.). Interviews were guided by an interview guide, but participants were able to – and did – direct the course of the interview, refuse to respond to questions or probes, and ultimately decide which topics were of relevance or importance to the conversation. For example, some participants enacted their power to choose not to share particular stories in detail by driving the conversation away from my probes for deeper reflection or by asking me what I thought about the questions or topics that we were discussing (Limerick et al., 1996). Others used the interview space as an opportunity to actively reflect on their practice, engaging in meta-reflection on the interview and the data that we generated together.

Understanding the interview as a gift that participants give to the researcher (rather than something taken from a passive participant) is especially useful since "[gift] giving is generally not conditional on the uses that the receiver makes of the gift" (Oakley, 2016, p. 208). This conceptualisation acknowledges the trust that participants place in the researcher through giving (i.e., through participating and telling stories), and emphasises the respect that the researcher must enact toward the participant and their gift beyond the interview itself, throughout interpretation and dissemination of the research (Limerick et al., 1996). Indeed, outside of participatory research approaches, participants often give more than the researcher will give 'back' or return to them (Oakley, 2016). Moreover, while participants are actively

engaged in the data generation process, the researcher retains all power in the interpretation of the data to produce an analysis and final product.

Given the emphasis on respect, relational ethics can also encompass the action of returning to the field through sharing research findings with participants (Tracy, 2010). I engaged in this practice by producing a plain language summary of the project and disseminating this to all participants (with their prior consent: Appendix J). This summary also provided me an opportunity to communicate preliminary recommendations for improving sexuality-related practice to the participants. I hoped that this would prompt them to reflect further on their practice and to engage in conversation with their colleagues (i.e., to contribute to improved sexuality-related practice in mental health settings, which was the broader purpose of this project). Nonetheless, producing and sharing this summary with participants was primarily an act of respect by returning to show them what I had done with (or, how I had interpreted) their words and stories – their gifts.

2.6.2.3. Exiting ethics.

The notion of maintaining respect for participants and their gift throughout the research process is implicated in a broader concern for ethical practice as the researcher moves beyond the data generation phase of research. Exiting ethics encapsulate ethical concerns in navigating the interpretation of data and dissemination of the work in a way that is both respectful to the participants and aligned with the aims of the research (Tracy, 2010; Yardley, 2000). Moreover, exiting ethics encapsulate a broader (macro) concern with how the knowledge claims produced through the research will be taken up or put to use within the broader social, economic, political, and cultural context (Brinkmann & Kvale, 2017; Chamberlain, 2015). Just as participants have no power regarding the researcher's

interpretation of the data, the researcher cannot control how others will read, (mis)interpret, and (mis)use their published work (Chamberlain, 2015; Tracy, 2010). The researcher can, and should, actively consider these macro-ethical dimensions of their research (Brinkmann & Kvale, 2017).

One way that the researcher can orient to macro-ethical concerns is by considering carefully who, or which groups, may benefit from the knowledge produced through the research and who may experience loss (e.g., Chamberlain, 2015; Fine, 1994). This loss could be in the form of autonomy, financial capital, or relational power, or in the form of continued subjugation. Psychological research about health and illness has been used, both by academic researchers and by others such as policy makers or researchers in the private sector, to reinforce institutionalised power relations which necessarily function to maintain the subjugation of various groups (e.g., see Brinkman & Kvale, 2017). Conversely, research within a critical health psychology framework aims to orient toward, identify, and disrupt inequitable power relations (as discussed in section 2.3: Crossley, 2008; Lyons & Chamberlain, 2017; Marks, 2002). Researchers working within this framework may therefore aim to write (or research) with, or for, groups who have traditionally experienced losses as consequence of knowledge production within psychology, medicine, and related disciplines. While the research presented in this thesis focuses on the perceptions of mental health clinicians, the overarching aim of the project is to contribute to broader efforts in improving individuals' experience of mental health care; specifically, to better ensure that individuals' sexuality and sexual needs are adequately met within mental healthcare settings where relevant. The complex issue of using research to write for, with, or even against, particular groups (Fine, 1994) is explored further in the following section on reflexivity.

2.6.3. Doing reflexive research.

Reflexivity in qualitative research refers broadly to the practice of actively orienting to and reflecting on research as a human activity that is carried out by social beings (researchers) who are not separate from the world in (and about) which they conduct their research. Engaging in reflexivity or being actively reflexive throughout the research process is an important part of doing high quality qualitative research (e.g., Chamberlain, 2015; Tracy, 2010). Reflexive practice is understood as contributing to sincerity and transparency in qualitative research (Tracy, 2010; Yardley, 2000) and is interwoven with, and necessary for, engaging in ethical practice throughout the research process (Guillemin & Gillam, 2004; Macleod et al., 2018). The researcher's consideration of the social and political impact that their research may have (Yardley, 2000), including who may experience gains or costs as a result (discussed above), is an ethical question that cannot be addressed except through reflexive consideration (Chamberlain, 2015).

While reflexivity is an accepted, even expected, practice within qualitative research (Finlay, 2002), there is disagreement about how to engage in this practice and what it should (or can) achieve. Many ways of engaging in reflexivity are available and, similarly, a range of typologies for classifying these approaches have been offered to guide researchers in doing this (e.g., Chamberlain, 2015; Finaly, 2002; Willig, 2013). These typologies are not "tidy, exhaustive and independent categorisation[s]", however, but "heuristic classification[s] of inter-related reflexivities" (Chamberlain, 2015, p. 176). Indeed, reflexive practices or approaches are overlapping, and researchers will usually draw on a range of these throughout their research (Finlay, 2002).

Although there are many ways of engaging in reflexive practice, it is important that the approach(es) selected 'fits' with the researcher's philosophical and methodological choices and assumptions (Finlay, 2002). Accordingly, the reflexive approach(es) that I have engaged within the project are aligned with those commonly taken up in research underpinned by social constructionism. So, I have sought to actively reflect on and examine how the data that participants and I generated together in interviews were shaped by our social identities and the power relations within those interactions; and how these identities (and interactions) shape the way that I interpret these data and generate analyses. These reflexive practices, discussed in more detail below, fit into typologies of reflexivity that that Chamberlain (2015) broadly classifies as "methodological reflexivity" (p. 168) and Finlay (2002) calls reflexivity as "intersubjective reflection" and as "social critique" (pp. 215, 220). Moreover, these map onto (and were implicated in) considerations regarding relational and exiting ethics, discussed in the previous section, whereby engaging in reflexive practice throughout the processes of data generation and interpretation allowed me to actively consider both the "situated and negotiated nature of the research encounter" and the power dynamics and "tensions arising from different social positions" of myself as researcher and participants (Finlay, 2002, pp. 215, 220).

In considering how the research processes are shaped by my own and others' social identities (and by my epistemological and personal values and assumptions), I necessarily engaged in aspects of what is broadly referred to as self-reflexivity, introspection, or reflection (Chamberlain, 2015; Finlay, 2002). Self-reflexivity is considered to contribute to transparency, trustworthiness, and credibility of qualitative research (Tracy, 2010; Yardley, 2000). This occurs through, for example, situating myself and orienting to my active role within the research, sometimes demonstrated in the reflexive statements included in

published manuscripts. Within a social constructionist perspective, positioning the researcher in relation to their values, interests, assumptions, and social identities through self-reflexivity or introspection is not about identifying and reducing researcher *bias* (or, increasing verisimilitude) but, rather, situating the researcher to provide context for the audience so that they may better engage with and interpret the knowledge generated by that researcher (e.g., Chamberlain, 2015; Finlay, 2002).

I am a white, able-bodied, queer identifying cisgender women younger than 30-years. My initial interest in sexual health-related experiences in health care settings was prompted by my own dissatisfying experiences in accessing (medical) sexual health care, and the similarly negative anecdotal experiences of many of my peers. This project developed over time to become situated within the context of mental health and, more specifically, in clinicians' perceptions of sexuality (rather than individuals' experiences of engaging mental health services, for example). It was driven also by my personal values, which I found to be strongly aligned with the critical health psychology politics of equity (discussed in section 2.3): In particular, my view that no individuals or groups should be denied sexual citizenship due to, for example, illness experiences, disability, or sexuality identity. These values are located in my politics and feminism, and in my experiences as a queer identifying woman.

Reflexivity, like research more broadly, must be useful. Criticisms of *self*-reflexivity in particular as banal 'naval gazing' are long standing (e.g., see Rooke, 2012). Finlay (2002) has similarly cautioned against becoming trapped in an "infinite regress of excessive self-analysis and deconstructions" (p. 212). Reflexive practice (particularly in relation to the self/researcher) must advance the research by providing "a springboard for interpretations and more general insight" (Finlay, 2002, p. 215). For example, those specific identities,

experiences, and values which I claim (outlined above) are relevant to the way in which I engage in or do research throughout the project presented in this thesis, including the way that data were generated (by myself and participants) and interpreted (by me, in reflection with my supervisors). I also inhabit and perform a range of other identities that I do not recognise as being directly relevant to these research processes.

It is in regard to the use(fulness) of reflexivity, specifically in establishing or evaluating the quality of qualitative research, that a second major critique – or danger – of engaging in reflexive practice arises: The concern that reflexivity is *performed* rather than practiced, and thus taken up as a rhetorical strategy bolster the researcher's "authority and credibility" (Finlay, 2002, p. 226). Other scholars have similarly argued that researchers often risk engaging in reflexivity in a way that is only performative and which, far from advancing the research, acts to re-invisibilise the researcher's active presence in the research (Stewart, 2018). This might be more likely if researchers approach (self-) reflexive practice as a bounded task that can be completed in order to render the research less biased (i.e., more authoritative: Stewart, 2018). On the contrary, reflexivity is an ongoing practice and reflexive considerations can, or should, be embedded into the research process at all stages (Macleod et al., 2018).

I engaged in reflexive practice(s) in relation to myself as (active) researcher and broader methodological considerations throughout the research process. I did this primarily by maintaining an audit trail which included reflexive journaling, whereby I specifically and actively reflected on my subjective experiences within the project and ways in which my wider experiences and ideas shaped or were shaped by my research (Finlay, 2002; Treharne & Riggs, 2015); and by engaging in ongoing discussions with my supervisor(s), mentors, and

colleagues about this research, my interpretations, and broader methodological concerns. In the sections below and the next chapter, I explore further some specific reflexive considerations regarding the generation and interpretation of data within this project.

2.6.3.1. Making data together.

The research interview can be understood as a social interaction or relationship in which the researcher and participant co-generate[22] "knowledge, meanings and narratives" (Vähäsantanen & Saarinen, 2012, p. 293). As discussed earlier, the research interview is a site of dynamic power relations that are negotiated by the researcher and participant throughout the interaction (see section 2.4.2.). Within a social constructionist perspective, the interview data are not a direct and objective window to participants' experience, nor is the interview a process of 'taking' meaning from passive participants. Rather, the participant and researcher are engaged meaningfully in telling stories and making meaning within the specific historical and cultural context in and about which they speak and live: the data are both a gift from the active participant (discussed in section 2.6.2.2.) and co-generated by participant and researcher. The data are therefore shaped by who the participant and researcher are and how they 'show up' and negotiate power within the interaction.

A myriad of factors influence the research interview and the continual negotiation of power within this, including the social identities of the researcher and participant and their experiences (shaped by these identity positions) prior to and during the interview (Manderson, Bennett, & Andajani-Sutjahjo, 2006; Vähäsantanen & Saarinen, 2012). That is, the identity positions that the researcher and participant bring to (and perform in) the

[22] I use the term 'co-generate' to indicate the reciprocal and collaborative nature of data generation within in-depth qualitative interviews, insofar as both interviewer and interviewee are active participants who contribute to and shape those data.

interview, including age, gender, ethnicity and cultural background, socioeconomic status, profession and professional status, and sexual identity, shape the way that the interview happens and, therefore, the data that the researcher and participant make together.

The nuanced power dynamics within interviews, and the data that participants and I generated together, were shaped by a myriad of social identity positions. I perceived less social distance between myself and some participants compared to others, such as those who were closer to my own age and those who shared specific disciplinary knowledge with me (i.e., psychologists). This seemed to impact the ease with which we communicated, including my own comfort within the interview (recorded in interview summaries), the kinds of listening behaviours that I performed, and whether I used vernacular language. This perceived social distance was shaped by characteristics such as age and gender as well as professional background; I am not a clinician, but my tertiary education has been in psychology and so, professionally, I was much more similar to psychologists than to nurse or psychiatrist participants. Interestingly, although I am not a clinician and have no clinical experience (which I was forthright about), at the time of conducting interviews I was enrolled in a clinical training program to become a registered psychologist. Although I chose not to complete this program[23], participants did meet me as a student clinician. From their perspective, this may have had an impact on their willingness to participate in the research and reduced the perceived social distance between us, compared with if I had been positioned as a non-clinical researcher.

[23] In Australia, a PhD in psychology does not qualify an individual to practice as a psychologist. At my institution, graduate programs in Psychology include a PhD (i.e., research only), a Master of Psychology (clinical practice pathway), or a combined program. I initially enrolled into a combined program but found that I wanted to focus entirely on research, rather than also becoming qualified to practice clinically. During the data generation phase, I was still enrolled in the combined program but had not commenced the clinical training component.

In particular, I have spent time reflexively examining the impact that (non)disclosure of sexual identity had on the direction and content of the research interviews. Although I disclosed or openly performed many social identity positions within the interviews, I did not disclose my sexual identity (queer) to participants nor request that they disclose theirs. The interviews were focussed conversations about the participants' perceptions and understandings of sexual expression, sexuality, and sexual health, however, and I became aware at many points throughout data collection that our (or my) nondisclosure only hid sexual identity within the interview and did not silence this; our hidden sexual identities, and the experiences and assumptions in relation to these, nevertheless shaped our interaction (McDonald, 2013). This became a major point of tension for me during (and beyond) one interview in particular, in which I was unexpectedly confronted with views about gender and sexuality diversity that I interpreted as specifically hurtful (though not directed *at me*). My emotional response to this and the consequent shift in the interaction with this participant prompted me to examine more closely the ways in which *non*disclosure of sexual identity may have shaped the data co-generation with all participants. This tension is examined in detail in Chapter Three (a submitted manuscript).

2.6.3.2. Building stories, constructing others.

As discussed previously, researchers need to consider the broader, macro-ethical context in which they generate and disseminate knowledge, including who this knowledge has consequences for and how (see section 2.6.2.3.). At the basis of these considerations is a need to consider how we represent others, or including participants, in our research (Chamberlain, 2000); or, how we construct others through building particular projects, asking particular questions, generating data in particular ways (including through in/exclusion of various potential stakeholders), and interpreting those data to generate particular knowledges.

Fine (1994) has mapped out a reflexive approach to considering how researchers inevitably construct others (participants) through her concept of the hyphen. The hyphen represents the juncture between Self/Other through which identities are formed, where identities are understood through a postmodern lens as constructed, performative, multiple, and shifting[24]. Research can thus be reinterpreted as 'stories about stories' (Fine, 1994; also see Limerick et al., 1996), or more specifically as researchers' situated stories about participants' situated stories. This positions researchers as necessarily active and present in both researching *and* storying, or constructing, the Other. Like Yardley (2000), Fine understands research as inherently political, arguing that the researcher is always necessarily working (or writing) with, for, or against the Other in producing research. Researchers must therefore acknowledge and 'work the hyphen' by actively considering how they construct the Other (participants) and what are the ethical and political implications of doing so, including how the knowledge produced may function to challenge, reimagine, or reproduce inequitable power relations.

The concept of (working) the hyphen has important implications for how the relationship(s) between researchers and participants is approached and understood in terms of the identity positions that they inhabit and the consequent power relations that shape and are shaped by the research processes. A useful, albeit somewhat limited, heuristic in approaching these relationships has been to understand researchers as being 'insiders' or 'outsiders' in relation to the population they are researching according to relevant identity categories (e.g., Wigginton & Setchell, 2016). Researchers can be insiders or outsiders, or both, in relation to

[24] Social constructionist approaches have been influenced by postmodern and poststructuralist theories (see section 2.2). Consequently, social constructionist approaches to social identity categories as constructed, performative, and plural are aligned with Fine's postmodern approach discussed here.

participants, and they may choose to actively reflect on how this positioning and the related power dynamics shape or constrain the ways in which they generate data with participants and interpret those data. Within Fine's (1994) framework, outsider research with 'vulnerable' groups is potentially disempowering and ethically suspect (e.g., research where participants experience mental distress or illness, but the researcher does not have lived experience or is in a position relative authority, such as a clinician). This relationship necessarily constitutes 'writing *for* the Other', discussed below, and therefore risks reproducing inequitable discourses and power relations.

Within the research presented in this thesis, I theorise myself as simultaneously *neither* and *both* insider and outsider in relation to two Others who I write: The participants, who are mental health clinicians and who I construct directly through interpreting the data we co-generated; and people experiencing mental distress or illness, who I construct indirectly through participants' accounts and the broader literature. I am both/neither insider/outsider in relation to clinicians because my tertiary education has been in psychology where I learned about dominant understandings of mental illness, and I presented myself to participants as a student clinician (insider); but I am not a clinician and do not have clinical training or experience (outsider). I am both/neither insider/outsider in relation to individuals who access mental health services because I do have personal experience of mental distress and have engaged various mental health professionals throughout my life (insider); but I have never accessed psychiatric inpatient services (voluntarily or otherwise), had my autonomy questioned and rights curtailed, or experienced discrimination or prejudice in relation to a mental illness diagnosis (outsider[25]: e.g., see Cromby et al., 2013).

[25] There are many ways to experience mental distress. While my personal experiences and positioning mean that I might be an insider at some points along that spectrum, I am not *therefore* an 'insider' in relation to all

As both/neither insider/outsider in relation to these two groups, or Others, I simultaneously construct both yet write *with* neither. My ambiguous positioning in relation to participating clinicians does not present an ethical dilemma in and of itself because mental health clinicians are not considered to be a vulnerable or subjugated group[26]. I write *for*, but not *with*, this professional Other by recognising that they work within and are constrained by broader, complex contexts. I also write '*against'* this group because I challenge and disrupt their authority as professionals, "exploiting the privileged voices" of those who define, diagnose, and treat mental illness "in ways that [seek to] disrupt Othering and provoke a sense of possibility" (Fine, 1994, p. 79). This writing-against the professional Other is done *for*, but not *with*, individuals experiencing mental distress and who access mental health services. This presents an ethical tension. Individuals experiencing mental distress, and particularly those who identify or are identified as consumers, are potentially vulnerable to subjugation and oppression based on their group membership (e.g., Cromby et al., 2013; Happell et al., 2018; Scholz, Bocking, Hedt, Lu, & Happell, 2019a). Not only am I not an insider in relation to this group, I did not speak directly with people who access mental health services nor seek the advice or perspectives of consumer advocates within this project. Instead, I have relied on the translations of other researchers, on theory, and on the constructions of participating clinicians to build this Other; and, in this way, simultaneously silence them.

My position as outsider (or, at least, not insider) in relation to individuals experiencing mental distress may also be somewhat productive. This is because my outsider

individuals experiencing mental distress, especially people who identify or are identified as consumers (and assigned SMI diagnoses). It is this point that I aim to acknowledge and write into here.

[26] As evidenced, for example, by my 'low-risk' ethical approval (see section 2.6.2.1.)

(and academic) position may grant authority to my interpretation and knowledge claims, where insiders/the subjugated Other is "more likely to be heard as biased, self-interested, or without distanced perspective" (Fine, 1994, p. 80. Also see Wigginton & Setchell, 2016). This does not resolve the tension of storying or constructing others (indirectly) through research processes; I am still writing *for* a group that has been, and continues to be, subjugated by authoritative voices or discourses, and particularly by discourses reproduced within the discipline of psychology, where I sit (Fox et al., 2009). I therefore risk reproducing harmful or disempowering discourses and power relations, even where this is not my intention and *even* where I endeavour to ask questions of and interpret data (co-generated with the professional Other) from a 'critical' perspective. I attempt to manage this tension within this project by being reflexive and transparent about these processes and dilemmas within my research. Moreover, in drawing on the wider literature to direct the project and interpret the data, I privilege research that explores directly individuals' perceptions and needs in relation to sexuality, and (or) that does not directly reproduce harmful discourses. Further considerations about how I and other researchers in this field might improve our research practices in relation to this dilemma in the future are outlined in Chapter Eight (section 8.5).

2.7 Summary

In this chapter, I discussed the theoretical and methodological frameworks that underpin this thesis and described how these were operationalised within or directed the research presented here to enable a critical analysis of how mental health clinicians understand sexuality and sexual health within mental health settings, and how they orient toward or away from these in their clinical work. I outlined processes and decisions in relation to data generation and analysis, including missteps that demonstrate my learning.

Throughout this project, I have endeavoured to conduct qualitative research that is rigorous and of high quality, demonstrated in part through focussed exploration of quality in qualitative research and of ethical reflexive processes relevant to this thesis. Chapter Three presents a manuscript that carries on these reflexive considerations, exploring a specific methodological dilemma encountered early in the project and that has shaped the way I engage with and interpret the data. This is therefore relevant to the reading of the analyses presented in Chapters Four to Seven, and so it is presented ahead of those.

CHAPTER THREE: Hidden but Not Silent: A Reflexive Account of (Non)Disclosure of Sexual Identity in Qualitative Interviews

Statement of Authorship

Title of paper	Hidden but not silent: A reflexive account of (non)disclosure of sexual identity in qualitative interviews
Publication status	Submitted for publication in *Qualitative Research*, under review

Principal author.

Name of principal author (Candidate)	Kristi Urry		
Contribution to paper	Developed rationale for the study and planned and carried out data collection (research interviews) discussed in this manuscript (under supervision). Engaged reflexively with the data, method(ology), and relevant theory to generate the ideas presented in the manuscript. Drafted, wrote, and submitted the manuscript.		
Overall percentage (%)	100%		
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the sole author of this paper.		
Signature		Date	23/06/2020

Abstract

This article presents a reflexive account of nondisclosure of sexual identity in a qualitative research project that explored mental health professionals' understandings of sexuality in their work. I did not disclose my own sexual identity (queer) to participants, nor request that they disclose theirs. I had not considered how our sexual identities, even hidden, might shape our interview interactions until one participant expressed views that surprised me as a researcher, and hurt me as a queer (cis)woman. I use this interview to reflect on how nondisclosure was both generative and limiting for data co-generation within this research; and the ways in which disclosure might have shaped the data too, only differently. In offering my own reflections regarding (non)disclosure of sexual identity in interview-based research, I aim to provide a context with which others might think more critically about their own methodological choices regarding (hidden) social identities and disclosure.

Keywords: Qualitative research; Research interview; Reflexivity; Sexuality; Identity; Queer

Introduction

As part of my doctoral research I conducted qualitative interviews with Australian mental health clinicians to explore their perceptions of sexuality and sexual health in the context of their work. As a student researcher and novice interviewer at that time, I was unprepared to encounter the views of one participant, a clinician called Jill[27], which I interpreted as homophobic. As a queer-identifying (cis)woman, this interview became difficult for me. As a researcher talking with participants about sexuality within the context of their professional work, this was also the first time that I had considered how our sexual

[27] To maintain anonymity, this pseudonym is unique to this article and I have not stated Jill's mental health profession.

identities might shape these interviews. Indeed, my decision not to disclose my sexual identity to participants, nor request that they disclose theirs, had implications for my research processes, particularly data co-generation[28]; it is my retrospective reflections of these that I focus on in this article.

Our identities, both salient and hidden, shape our interactions and experiences and, therefore, the way that our research happens (Manderson et al., 2006; Wagle & Cantaffa, 2008; Wilkinson, 1988). Many scholars have reflexively explored how differences and similarities between researchers and participants along intersecting social identities or categories, including gender, age, ethnicity and class, (re)produce power relations that shape the research processes, particularly data generation and the researcher's interpretation of the data and subsequent knowledge claims (e.g., Fine, 1994; Finlay, 2002; Manderson et al., 2006; Pini, 2006; Wagle & Cantaffa, 2008). The (non)disclosure of the researcher's sexual identity where the participants are not necessarily lesbian, gay, bisexual, trans, queer, intersex, or asexual (LGBT-QIA) identifying (i.e., where there is no direct concern about the researcher's insider/outsider status), but where sexuality is the topic of the research, has not been widely discussed. In this article I aim to extend the existing dialogue regarding researcher and participant sexual identity by reflexively exploring how (non)disclosure may shape the process of data co-generation, sometimes in unexpected ways.

My decision to hide sexual identity in interviews within a project exploring participants' conceptualisations of sexuality and sexual health was made uncritically and unreflexively. At that time, I did not yet have the tools to consider how this decision might shape my research. This article is intended to provide some context for others setting out on

[28] See footnote 23 on page 104.

similar journeys and who are also struggling to think about, or failing to recognise, how sexual identities and (non)disclosure might impact their research. My aim is not to provide a definitive formula regarding disclosure of sexual identity in interview-based research, but to offer my own experiences and reflections as a context with which others might think more critically about their own methodological choices regarding (hidden) social identities and disclosure within their research (also see McDonald, 2013).

In the next section, I provide a brief account of the theoretical perspective through which I engage this reflexive practice, and the project in which it is situated. I then put this theoretical grounding to work, reflecting retrospectively on how and why I decided not to ask participants to disclose their sexual identity, nor disclose mine. The interview with Jill catalysed my reflexive work around this dilemma of (non)disclosure, and I use this as a springboard from which to explore how sexual identity was hidden, but not silent, in the interview interactions specifically. This work is ongoing, but I close with some final thoughts about sexual identity and (non)disclosure in research.

Background: Sexual Identity and Reflexivity

Social identities are relational; they are meaningful specifically because they render people intelligible and contribute to (re)producing the social structure within in which we all conduct our lives (Burr, 2015a; Fine, 1994; Riggs & Treharne, 2017). Identities, including sexual identity, therefore impact the ways that we do research, including how we ask questions, interact with participants, and interpret data. Compared with other identity positions, there has been relatively less consideration of how sexual identity and (non)disclosure may shape research processes, especially where sexuality is a major topic of that research. Much of the published work that does explore researchers' sexual identity in

the field has focussed on non-normative identities, where either the researcher or participants (or both) are not straight identifying (i.e., heterosexual). Indeed, straight identifying scholars appear to reflect on their sexual identity within research less often than non-heterosexual scholars (there are exceptions, e.g., Braun, 2000), and I will return to this point in the final section.

Some scholars have explored, for example, nondisclosure of a lesbian or gay identity as a means of mitigating risk of stigma and violence in the (heteronormative) field, and the associated ethical dilemma of deception (La Pastina, 2006); or using disclosure as a tool to generate rich data when conducting research within sexuality and gender diverse communities (Rooke, 2012; Wagle & Cantaffa, 2008). The researcher's choice to disclose or hide their (non-hetero)sexual identity is often intended to be generative – facilitating access to the field and relationship building with participants – but it can also come to be limiting in other ways. For example, La Pastina's (2006) choice to "move back into the closet" (p. 272) while conducting fieldwork in a rural Brazilian community opposed to homosexuality was generative overall – it maintained his safety and access to the field – but it also limited his ability to co-generate rich data with gay men in that community. Indeed, the same identity position (and non/disclosure of this) can be both a "resource for and constraint on" the data that are co-generated within a single interview, across interviews within a project, and across projects (Vähäsantanen & Saarinen, 2012, p. 495).

Sexual identity is often assumed or perceived even in the absence of explicit disclosure. La Pastina (2006) and McDonald (2013) both chose to hide their sexual identity in the ethnographic field but found that their research, and especially data co-generation, was nevertheless shaped by the assumptions that participants held about their identities. La

Pastina explicitly deceived his participants, first by not correcting their assumptions that he was a straight identifying man and, later, by fabricating a heterosexual marriage and an imagined wife waiting for him at home. These lies were driven by participants' assumptions and questioning as they tried to make sense of him within their community; an apparently single man who refused all offers to be set up with young, single women. McDonald also chose not to disclose his identity when he began ethnographic fieldwork in a US-based sexual health organisation. He found that this organisation was homonormative, and gay-identifying participants spoke to and shared experiences with McDonald as if he were a gay man too. Though he did not explicitly deceive these men, McDonald chose not to correct or challenge their assumptions; instead, he kept his (straight) identity hidden until later when he did come to identify as non-heterosexual, and then choose to explicitly 'come out' to participants[29]. In both examples, participants made assumptions about the researcher's sexual identity based on the norms within the wider context – hetero- or homo- normative – and this shaped the way that they approached and made sense of the researcher within those spaces. Moreover, these assumptions shaped the way in which they formed relationships with the researchers and the co-generation of data.

While I found these reflexive accounts valuable in thinking about my own experiences and choices within the research process, I felt that they did not capture or reflect well the way that nondisclosure of sexual identity had functioned in my research, including data generation and analysis. The broader project within which this reflexive work is situated explored Australian mental health clinicians' perceptions and understandings of sexuality and sexual health in their work. This project was grounded in a critical, social constructionist

[29] A queer self-reflexive lens can orient to the instability and fluidity of identity and experience – or social location – in research. See McDonald (2013, 2016) for further articulation.

approach[30] (Burr, 2015a; Lyons & Chamberlain, 2017), and I generated data through in-depth interviews with clinicians who were working across a range of settings and sites in four Australian cities. I did not disclose my sexual identity to participants, nor request that they disclose theirs. Instead, sexual identity remained mostly hidden; but during and after the interview with Jill, I realised that this did not mean that sexual identity was silent in those interactions. Sexual identity had shaped the interview interactions despite – or because of – nondisclosure, and so I began learning about and engaging more deeply in (self-) reflexivity to explore this further.

Reflexive approaches are overlapping, and researchers often use or engage more than one approach when conducting (reflexive) research (Finlay, 2002). In this article, I draw on a social constructionist approach to reflexively examine how research processes, and particularly data co-generation, are shaped by the power relations produced by intersecting social identities between researchers and participants (Burr, 2015a; Fine, 1994; Finlay, 2002; Vähäsantanen & Saarinen, 2012). My reflexive practice is also informed by a queer reflexive stance, which allows the researcher to also consider how research processes are impacted by nondisclosed identities, participant and researcher assumptions about those identities, and identity flux or instability (McDonald, 2013, 2016). Although a range of social identities or positions contributed to shaping the interviews I conducted – including my positions as young, (cis)woman, and white – it is specifically the *non*disclosure of sexual identity, and the ways in which this hidden identity/(ies) produced dynamic power relations within interview interactions, that I explore in this article: sexual identity was hidden, *but not silent*.

[30] Consistent with this approach, I understand sexuality as a sociohistorically situated concept that refers to or encompasses much more than simply 'sexual identity' or orientation; but in this article I only refer to sexual identity.

A queer perspective also orients to the multiple and shifting positions of the researcher within the research interview and the research processes more generally, both at the time and over time (McDonald, 2015; Rooke, 2012). Just like social identities, reflexive practice is temporally situated (McDonald, 2013). So, it is possible, over ongoing engagement, to be reflexive about past reflexive practice – but only in so far as it continues to be useful or productive for the research (Finlay, 2002). This article has been constructed from ongoing reflexive practice over a period of nearly four years and is, in this way, a patchwork of (re-)reflexivity. This period includes the planning phases of the research project and the decision to hide sexual identity in interviews; the interview with Jill that catalysed my reflexive practice about this dilemma; the initial sharing of this reflexive work with colleagues; and the development of this article. The way that I engage reflexively with this dilemma of nondisclosure *now* is different to how I did so twelve or twenty months ago, and that was different to how I thought about this dilemma (as a non-issue) when initially planning the project. These changes have tracked closely with my ongoing learning about qualitative research methodologies and ways of approaching or thinking about research as an active, situated process. The reflexive work presented here draws on the transcript and field notes from the interview with Jill, conversations with my primary supervisor (recorded in the audit trail), the wider project audit trail, memos made in relation to Jill's transcript and the wider dataset, notes made while reading other's reflexive work or relevant theory, and memory work.

Hiding Sexual Identity

Hiding sexual identity (both my own and my participants') in interviews and, initially, the research project more generally was a pragmatic and un-reflexive decision made during

the early stages as I focussed on planning the project and gaining ethics approval. I did consider briefly the decision to not ask participating mental health clinicians to disclose their sexual identity, despite asking for other information including age, religious affiliation and gender identity. We were primarily interested in participants' perceptions of sexuality *in their work* rather than their personal lives, though we acknowledged at the time that these do not exist in isolation. Given that sex and sexuality tend to be taboo and highly moralised social concepts (Weeks, 2010), there was a concern that recruiting mental health clinicians to talk about these topics could prove challenging (it was). We worried that also asking clinicians to talk about sexuality beyond or outside of their work (i.e., in relation to their personal selves or lives) may have been additionally discouraging, such that even fewer clinicians volunteered to participate.

For the reasons above, we decided that I would not directly ask participants to discuss sexuality or sexual health beyond their work, nor disclose their sexual identity, but that I would welcome it in the interview if they raised these conversations themselves. Many participants did talk about experiences in their personal lives that they felt were relevant to the stories they told me about experiences in their work. For example, one participant told me how she incorporates into her work with adolescents the kind of sex-education that she wishes she had have received when she was young. Three participants explicitly disclosed their sexual identity: two "gay" men and one "heterosexual" woman (Jill). I would argue that all participants' sexual identity (and their experiences in relation to sexuality more broadly) was important to the way that they perceived these topics in their work; but these three participants, and particularly the two gay identifying men who disclosed very early on in the interviews, could not talk about sexuality in their work without also orienting to or disclosing their own sexual identity. Other participants used language and made comments that might

imply that they were straight identifying and some, based on my assumptions and on knowledge outside of the project, chose not to disclose their non-heterosexual identities.

In contrast to the decision not to ask participants their sexual identity, I gave the decision to hide my own identity almost no consideration. This likely reflected my transition, at that time in its infancy, from empiricist psychological research that discounts researchers' active role in knowledge production to critical epistemologies that orient to the situated nature of knowledge and the active research processes through which it is produced (Burr, 2015a; Lyons & Chamberlain, 2017). I did not consider how hiding (my) sexual identity during interviews might impact data generation because I did not yet have the tools to consider this choice in a critical or reflexive way (or even recognise that I was making a *choice*). By contrast, I have now spent time reflecting and being reflexive about this nondisclosure through journaling, discussions with my supervisor(s) as I (learn to) move through analyses, and in conversation with the broader research community. These processes helped to familiarise to me with the tools that I needed to engage reflexively with nondisclosure in this research, and provided the space to do so.

Additionally, the way that I identify, relate to and perform my sexual identity has not been static over the course of my doctoral degree. While I did not shift from an initially straight identity, as McDonald (2013) reflected on, the label that I use to identify myself and the experiences that I have in relation to this identity have shifted over time. The label that I use to identify my non-heterosexuality sometimes shifts depending on the social context but 'queer' – the label I use most often – was not an idea I used to label myself before undertaking this project or even at the time of submitting the ethics application. Retrospectively, I do not know how I might have positioned myself if I had wanted to

disclose my sexual identity within the project; and perhaps this contributed to my inability to consider (non)disclosure more thoroughly.

It is relevant here to note briefly that the way I use 'queer' as a label is both political and aligned with a queer approach. Claiming 'queer' as an identity category does not imply engagement with queer theory (indeed, these can even be at odds: see Jagose, 1996; Riggs & Treharne, 2017); but it does not necessarily preclude it. I use queer to identify myself specifically because of the ambiguity, messiness and non-specificity of what it does or, rather, does *not* denote (Jagose, 1996; Sullivan, 2003). This oppositional 'queer' certainly contributes to the way in which I think about and practice research and reflexivity; and, no doubt, my process(es) of identifying or locating myself has been shaped by my research and academic learning (Wilkinson, 1988). Moreover, while my use of 'queer' is queer, it was on becoming more connected with gender and sexuality diverse communities, and not learning about queer theory itself, that I initially took up this label in this way.

I also very easily pass as heterosexual in my everyday life, and this also contributed to the (non-)decision to hide my sexual identity in interviews. That is, because I do not consistently disclose or perform a queer identity and most of my interactions take place in heteronormative contexts, I am often presumed hetero/normative until I disclose otherwise (e.g., Kitzinger, 2005). My consistent experience of passing means that also I take it for granted that I will be presumed straight across a wide range of contexts and situations[31]. My research, which was conducted in a mainstream and therefore heteronormative (mental) health context (e.g., Semp & Reed, 2015), was no exception; I took it for granted that the

[31] See Urry and Pearce (2019) for a deeper exploration into the (my) everyday experience of identifying outside of a heteronormative framework, and the pervasive cultural understanding that sexual identity (and desire) is binary; either straight or lesbian/gay, but not neither.

clinicians who participated would likely presume that I was straight, *and* that this would be quite irrelevant in the broader context of the project. I believe that Jill, the participant whose interview catalysed my reflexive practice in relation to (non)disclosure of sexual identity, did assume that I was straight even though she came to understand that I did not share her views about gender and sexuality diversity. I also believe that she would not have shared these views with me – or shared them in the same way – if I had disclosed, rather than hidden, my queer identity.

In the next section I use Jill's interview as a starting point from which to reflect on the ways in which nondisclosure may have shaped the co-generation of data within my doctoral research. First, I give a brief account of the interview and situate Jill's views within the wider dataset before turning my attention to the specific incident within that interview that catalysed this reflexive work. I then use this as a springboard from which explore how hidden (sexual) identities shape the co-generation of data. Specifically, I consider how (non)disclosure may be either, or both, constrictive or generative within the context of data co-generation.

Doing (Noisy) Silence, Doing (Quiet) Queer

The interview with Jill was the thirteenth that I had conducted; ever, and within this particular research project. I met her at the end of the day at her workplace, a mental health service that mainly engages people with 'serious' mental illness diagnoses where she worked in a clinical management position. We sat and talked together for eighty-minutes in a room that is used for meetings between clinicians and individuals who are engaging the service (similarly to many other clinicians who participated in this research, Jill did not have a private office space). Jill was over sixty years of age and, by her own account, "very much on

the old edge of things". She saw herself as a "reasonably typical" member of her profession with "fairly conservative values", and was quick to locate herself as working from a place of compassion and care.

Throughout the interview, Jill drew on normative understandings of sexual and gender identities as binary and interrelated (i.e., the idea that one determines or can be inferred from the other), and heterosexuality as normal and natural. These were often constructed within a broader context of (or to justify) essentialist understandings of gender roles and sexual desire; where women are naturally nurturing and lack sexual desire, and men have a high biological need for sex (Hollway, 1984). Jill was not unique in this way; many other participants in the project also constructed or drew on pervasive (hetero-) normative discourses when talking about sexuality and sexual health in their work. For example, it was common for participants to exclusively use heteronormative examples when discussing sexual expression and health, to centre the penis and men's pleasure in accounts of legitimate expressions of sexuality (usually heterosex, or penile-vaginal intercourse), and to infantilise women in regards to sexual desire or reproductive decisions (see Barker et al., 2018).

> sexual health just means […] look[ing] after yourself in terms your sexual actions so basically […] for a man you need to be wearing a condom or if you're a woman then you've got to make sure that the guy's wearing a condom. (Jake)

Very often, heterosexuality was an "unquestioned and unnoticed" position from or through which participants talked about sexuality, working to both reflect and construct heteronormativity (Kitzinger, 2005, p. 223). I was prepared to encounter this kind of mundane heterosexism within the research interviews (Braun, 2000; Peel, 2001); this is a normal part of my everyday life as a (passing) queer woman, after all. I was not prepared to

encounter blatant (though never *direct*) heterosexism and prejudice like I did in conversation with Jill, discussed further below. As I reflected in my field notes, *Jill expressed, by far, the most transphobic / biphobic / homophobic views (in that order) that I have encountered during this research. It may not be that she is the only participant […] to feel this way, but she is the only one […] who has talked openly about such views*. In retrospect, I should have been more prepared to hear this. Although the data she and I generated were somewhat exceptional within in the wider project, her views do reflect the negative mental health care experiences of LGBT-QIA identifying people reported in the literature (e.g., Kidd et al., 2011).

Throughout the interview, Jill never directly said that people who identify outside of normative sexuality and gender categories are unnatural or bad; but she persistently positioned non-normative identities as deficient, deviant or unnatural. For instance, Jill regularly constructed homosexuality as being specifically connected with mental illness and sexual deviancy, including paedophilia. Particularly within the context of mental illness diagnoses, Jill understood non-normative identities as artefacts of childhood sexual abuse, as symptoms of distress, or both. Such identities were only "authentic" if the individual was certain of their "choices", but the bounds within which this authenticity could be achieved were persistently questioned, both within the context of mental illness diagnoses and society more broadly. Non-normative identities thus had to be proven, while the authenticity of heterosexuality and cisgender identities was never challenged in this way.

> […] if somebody's sexually healthy it means that in all respects they've got a very good idea of whether they're male or female or they [… are] absolutely convinced, with no psychosis involved at all, no delusional content at all, that they are meant to

> be transgendering [sic] from one to the other. Okay or they can emerge as either lesbian or homosexual if they really feel that this is who they're meant to be and everything confirms that [for them]. (Jill)

Towards the end of our eighty-minute interview, I asked Jill about her sexual health-related training. She talked about a range of topics that had been touched on during her professional education including, briefly, LGBT-QIA health. Jill took this opportunity to shift the conversation to her concerns with the work of the *Safe Schools Coalition Australia* (*Safe Schools*) which was being fiercely debated in Australian politics and media at that time (Thompson, 2019); *Safe Schools* was intended to promote safe and supportive school environments for all students, especially LGBT-QIA identifying students. Aligned with the broader anti- *Safe Schools* discourses circulating at that time (see Thompson, 2019), Jill's concern seemed to be that *Safe Schools* was "taking advantage" of a "natural" adolescent stage of sexual ambiguity and discovery; and, in doing so, that it was potentially manipulating some young people into identifying as gender or sexuality diverse who would have otherwise "st[u]ck with their own true selves… That if they're born male they are male, if they're born female they are female" (and heterosexual). As I interpreted it, Jill perceived *Safe Schools*, and the LGBT-QIA community(/ies) by extension, as being specifically dangerous to the wellbeing of young people and to society by extension.

> It worries me too that maybe… I'm going to be honest and say that I think there's bit of a predatory movement going amongst young people [through *Safe Schools*]. (Jill)

While Jill explained these concerns, I worked hard to keep a neutral expression on my face and decide what to do. I did not want to explore her ideas further and I did not want to challenge or push back on her ideas. I kept my queer quiet and listened out for an opportunity

to move away from this conversation. At the same time, I felt that it was critical that I did not appear to agree with or legitimate these views. I often perform active listening in interviews with 'mm's, nods and eye contact but now I sat quietly and still, averting my gaze more than usual. This silence was evidently noisy enough for Jill to notice, and she began to close the topic herself:

> **Jill**: I'm very worried about that program […] ((Pause)) Now you can be quite critical of my attitude but I'm very very worried that it's all happening at a too young- too vulnerable age.
>
> **KU**: Thank you for sharing that with me – […]
>
> **Jill**: – Yeah. ((Overlapping speech))

Over the course of the interview, and then as Jill had shared this particular story, I experienced a tension between recognising, as researcher, that the data being generated were incredibly rich and, as queer woman, feeling Other-ed and intensely vulnerable; this is a tension that I continue to negotiate in engaging with these data. In choosing to share this story, Jill had moved the interview into a highly politicised space where non-heterosexual identities and the acceptability of these – including my own – was specifically contested. Doing research often means "moving within and between (social) categories" (Rooke, 2012, p. 39) including researcher, (young) woman, interviewee, expert, interviewer, novice, insider and outsider (Vähäsantanen & Saarinen, 2012). Jill's talk about *Safe Schools*, particularly within the context of the broader interview, dragged me quickly from *researcher, sexuality conveniently quiet* to *queer and questionable*. Though this shift remained hidden (I assume), it impacted the rest of that interview.

I could have sat with Jill and explored this story more deeply, eliciting further discussion as I might have (and did) with other uncomfortable topics including 'deviant' sexual expression or sexual violence. Exploring negative perceptions of *Safe Schools*, and of gender and sexuality diversity more broadly, might have been uncomfortable for another (straight identifying) researcher but, in that interaction when my sexual identity was made unexpectedly salient (to me) and denigrated, I was not able to safely do this. Instead, I began (trying) to close the interview. This choice was not based on my lack of interest as a researcher but, rather, on how I now felt in that space as a queer woman. My emotions shaped my research practice, the direction of the interview, and the remainder of our interaction; another eight minutes in which this topic of sexuality and gender diversity would not stay closed. I posed a clarificatory question about (what I thought was) a safe topic from earlier in the conversation and then shifted to collect some final demographic information; but in response to all of these, Jill continued to re-orient to sexuality and gender diversity, simultaneously emphasising her "respect for anybody that is very, very true to themselves" and her "very real concerns" about non-normative identities and the people who claim them. I increasingly refused to engage with Jill's talk, and was increasingly distressed by my inability to regain authority as the interviewer and shift/keep the talk away from this topic. Finally, I closed the interview and left. Back in my car, I emailed my primary supervisor to request a debrief and then cried before driving home.

This interview with Jill continues to have an impact on the project of which it is part, how I think about doing research more broadly, and on myself. During that interaction, my sexual identity was made prominent within the context of my doctoral research in a way that it had not been before. Moreover, this interview also happened at a time when this identity had been growing louder in my everyday life, partly because of the ferocity with which *Safe*

Schools (and marriage equality) was being debated in Australian politics, the media and online. Thus, this identity position had been becoming, and then suddenly became, a salient part of how I interpreted and thought about/with the data, the interview interactions, and the methodological choices that I had already made and would continue make (McDonald, 2013; Wagle & Cantaffa, 2008). In particular, I began to reflect on and think critically about how nondisclosure of sexual identity, both my own and the participants', shaped all the interviews that I conducted.

I first reflected on how the interview with Jill might have been different had I been a straight identifying researcher engaged in the same interaction. Hopefully I would not have shared her views, but I reasoned that my reaction to hearing them would probably not have been emotional and embodied; not personal. Instead, I may have felt and responded in a way that is similar to how I do when, as a white woman, I encounter racist talk in interviews and everyday interactions; feeling angered or appalled but not *hurt* by it and, indeed, likely encountering and (re)producing racism in ways that I do not always recognise (for a discussion of this idea in relation to heterosexism see: Braun, 2000; Peel, 2001). So, had I become uncomfortable but not *vulnerable* or *affected*, I might have probed further to encourage Jill to explore these ideas more deeply and particularly in relation to her work in a mental health setting. She did this somewhat, but I could have taken it further and I chose not to – could not – do this. In this way, the data that Jill and I generated together, particularly in relation to these specific ideas, were limited by my (hidden) identity position.

Nondisclosure did not always constrain data generation, though, even within the interview with Jill. As I reflected previously, Jill's willingness to even share this story may have been facilitated by my nondisclosure and her assumption (I assume) about my sexual

identity. Indeed, throughout the interview, and particularly during those final eight minutes, Jill positioned herself explicitly as heterosexual and LGBT-QIA identifying people as "them" / Other, but she never specifically positioned me. Even if she came to understand that I did not share her views, and if she was working to manage her accountability within our interaction as *not* homophobic, I remained audience to, but not positioned by, her talk: indicating that she perceived, and continued to perceive, me to be straight (Kitzinger, 2005). I had not previously considered the potential ethical implications of hiding sexual identity (particularly my own) during interviews where sexuality was a central topic in those interactions. La Pastina (2006) has explored the ethics of not only hiding his sexual identity (gay) but explicitly deceiving his informants about this during fieldwork in a rural Brazilian community where homosexuality was highly stigmatised. He would not have had the same interactions, and may not have been able to conduct that fieldwork, had he not allowed informants to believe that he was a straight man. So, was I also deceiving my participants by hiding my sexual identity? Not intentionally. I believe that I would have been open about my identity had a participant directly asked me about it or explicitly referred to me as being 'straight', because doing so would likely not have placed me in immediate danger.

In retrospect, when I initially chose to hide my queer identity, I did have some awareness that in doing so I might be more likely to hear heterosexist and prejudiced accounts. This was based on my everyday experiences where people are usually more careful in managing and performing social acceptability when my sexuality is known to them (i.e., by 'not doing' explicit heterosexism: see Peel, 2001). I cannot know for sure what participants assumed about my sexual identity or how those assumptions shaped our interactions. Nonetheless, in this way, my nondisclosure may have been somewhat generative or productive within the context of data co-generation. Perhaps Jill would have shared the

same story, or perhaps she would not even have agreed to participate, or continue participating, in the interview if I had disclosed. So, my choice to hide sexual identity was both a constraint and, potentially, a resource, on the co-generation of data throughout the project (see Vähäsantanen & Saarinen, 2012). Similarly, choosing to disclose my/our sexual identity/ies could also have been both generative and restrictive for data co-generation across interviews.

Disclosure of sexual identity could have been a tool for generating different and equally valuable data with participants who also identified as non-heterosexual (La Pastina, 2006; Wagle & Cantaffa, 2008); both those who disclosed this and those who (I think) chose not to. Sexual identity intersects with other identity positions and experiences so that two people who claim the same sexual identity will not have had the same experiences (McDonald, 2013). Disclosure can nonetheless be productive in interaction by "emphasising [the potential for] similarities and shared experiences" (Rooke, 2012, p. 33). Perhaps I missed opportunities to hear stories that could only have been generated within a context of "shared understanding" (Rooke, 2012, p. 33); a discursive space where sexual identity could be openly talked about and the participant and I could both feel safe to tell stories about or draw on our experiences as people who claim diverse sexual identities, regardless of how dis/similar those experiences were. Equally though, I wonder if disclosing my queer identity to straight identified participants might have closed some opportunities to co-generate data, particularly in relation to gender and sexuality, by emphasising our potentially disparate experiences.

Indeed, disclosing (my) sexual identity might have been restrictive in some interviews. Heterosexuality is, in most contexts, taken-for-granted and does not require

disclosure (e.g., Kitzinger, 2005). Orienting explicitly to sexual identity disrupts this norm by bringing attention to something that usually remains comfortably hidden (but not silent!), and so my disclosure (or request for this) could have been jarring or even uncomfortable for some straight identified participants (also see McDonald, 2015). This is especially pertinent since I was interviewing participants *as* clinicians in their workplaces (mental health settings), and clinicians' identities beyond *professional* or *expert* are often imagined to be irrelevant (e.g., see Riggs, 2011). Moreover, in choosing to disclose I would have faced an additional dilemma in deciding *how* to position myself. Queer[32], a reclaimed identity category, might have seemed strange or inappropriate to some participants. For example, one participant did not know what was meant by 'Q' in LGBT-QIA and her response to my explanation was one of perplexity because "you would never ever have called someone queer [in the past]" (Yvonne). Other participants talked about their colleagues' rejection of bisexuality as a valid identity on grounds that people should 'choose'. Indeed, any label that I used other than lesbian (which I have never claimed) may have been met with curiosity, misunderstanding, or withdrawal if, besides non-heterosexuality, poly-sexualities[33] were foreign or otherwise unintelligible to the participant (see Barker et al., 2018; Urry & Pearce, 2019). Certainly, this would have shaped our interaction and the data we co-generated.

So, disclosure of sexual identity would not have 'done' the same thing across all interviews. In some, disclosing sexual identity might have been a tool and worked to open possibilities for co-generation of different data. In others, 'queer' might have made me

[32] As started earlier in the article, I did not identify myself as 'queer' at the time of the interview with Jill; but had taken up this label by the time I stopped interviewing and have continued to use it throughout much of this reflexive practice. Prior to taking up 'queer' I preferred not to use any specific label, making disclosure complicated.

[33] Poly-sexuality simply refers to attraction or desire for more than one particular gender. Like heterosexuality, mono-normativity is a dominant sociocultural norm.

unintelligible or produced a power dynamic that closed or constrained some possibilities for generating data. Similarly, *non*disclosure of sexual identity – the option that I chose – did not do the same thing across interviews. Rather, nondisclosure and the "*interplay*" of this with other social identities was both a constraint on *and* a resource for generating rich data in interviews with mental health clinicians about their perceptions of sexuality in their work (Vähäsantanen & Saarinen, 2012, p. 459). This idea that the same identity position(s) can impact interactions in different ways was reflected by another participant who I interviewed a few weeks after Jill. Ben discussed how the (non)disclosure of disparate sexual identities within the therapeutic encounter can produce tensions that become either constrictive or productive.

> […] in terms of sexual orientation as well. If the patient perceives that the therapist or knows that the therapist has a different sexual orientation to them, in whatever way they know that, then it's interesting in terms of where that might lead a discussion about sexual health and might be an obstacle. Or what might be an easier path because of that. So they're very subtle dynamics between that dyad of [individual and clinician]. (Ben)

Ben's talk reflects the tension produced through the dynamic of assumptions and (non)disclosure around sexual identity; potentially hidden, but never silent. While Ben was interested in reflecting on these tensions, he never suggested that the clinician should disclose their sexual identity. I am similarly not suggesting that researchers *should* disclose their sexual identity to participants or demand reciprocal disclosures. Rather, I am arguing that researchers should reflexively consider their decision to disclose, or not, and the way(s) in which either choice will shape their research processes, particularly data co-generation

through interviews, focus groups, or other similar methods. Hidden or not, that sexual identity would shape the specific interviews that I conducted was unavoidable; but being reflexive about this has allowed me to think differently about and with these data, and to consider more deeply some methodological choices both within this research and for future projects.

I do not know if or when I will disclose my sexual identity to participants in future research. This will depend on how I identify at that time, what I am seeking to explore or do in the research, and who the participants are and how they identify (for a detailed discussion of the politics of self-disclosure in academia more broadly see: Barker, 2006). Whatever choice(s) I make, I will do so having considered carefully the ways in which this could be both a resource for and constraint on the co-generation of data within that project (with an eye to my inability to actually predict the future, or even a single research interview). Regardless of whether I choose to disclose or not, I hope to be more prepared (or, less startled) to hear stories and generate data that is personally and emotionally challenging for me.

Thinking Differently, Making More Noise

My writing this article is a very specific un-quieting of my queer identity within this research. It is also somewhat of an exercise of my power as researcher to interpret, analyse and have this final say (Fine, 1994; Vähäsantanen & Saarinen, 2012). Certainly, this reflexive work has been cathartic as well as being useful for my (and hopefully others') research. Certainly, doing research can be, and often is, "a form of emotional work" (Rooke, 2012, p. 32). Other scholars have similarly reflected on the emotionality of doing research and the often-embodied impact that negotiating sexual identity can have on the researcher in the field,

during interpretation of data, and writing up. Although "liv[ing] with the façade of a married [straight] man" in the field kept La Pastina (2006) safe and facilitated deeper access to some parts of a conservative Brazilian community, it also produced a deep loneliness and "*anxiety* about having to be back in the closet" (emphasis added: p. 726). The affective dimension of research is often "written out in the writing up process" though (Rooke, 2012, p. 26), seemingly in an effort to produce knowledge claims that will be read as rational and therefore trustworthy (Yardley, 2000). Articulated or not, research and its processes – from asking questions, to generating and interpreting data, to disseminating knowledge claims – is often emotive for researchers, for participants, and for readers. This does not reduce the value of that research; rather, orienting to and exploring these "affective dimensions" may add value by increasing transparency and acknowledging the rich complexity of knowledge production (Rooke, 2012, p. 26; Yardley, 2000).

I was 'in the field' and I conduct research as a queer identifying (cis)woman even if I did not, or do not always, disclose this (also see La Pastina, 2006). This non-disclosure had implications for me as a queer identifying (cis)woman exposed, unexpectedly, to heterosexism and as a researcher generating rich data about participating mental health clinicians' perceptions of sexuality in their work. Hiding sexuality – both mine and the participants' – contributed to the production of rich data that might not have been generated in those interviews if I/we had disclosed our sexual identities. On the other hand, nondisclosure might have been an obstacle to hearing different stories and generating data that could only be produced within a context of shared understanding (Rooke, 2012). The data that were generated are no more or less valuable than the data that could have been generated within the context of disclosure (La Pastina, 2006); only different. Indeed, if I/we

had disclosed sexual identity, then this would have also been both a resource and constraint for data co-generation (Vähäsantanen & Saarinen, 2012), but in different ways.

This conversation is not just about queer or non-normative identities, though. Sexual identity in research in not only worthy of reflection when it is Other. In similar interviews about the same topic, a researcher's heterosexual identity and their (non)disclosure of this would have been generative and limiting, too. Researchers' heterosexuality seems uncommonly explored though (but see Braun, 2000), except where participants are non-heterosexual and then there is concern about negotiating the researcher's potential outsider status (e.g., Levy, 2013). This quieting of heterosexuality is normalising. Indeed, it is specifically because heterosexuality is 'normal' that it is usually not oriented toward or considered worthy of reflection (Braun, 2000; Kitzinger, 2005; Peel, 2001; Rooke, 2012). Researchers may thus reproduce or reinforce heterosexism throughout their research in many ways, for example by failing to actively challenge, or even identify, this in interaction (see Braun, 2000; Peel, 2001). I have begun to reflect on how my choice to allow sexual identity to remain comfortably hidden, and therefore unproblematised, during the interviews I conducted might have worked also to reproduce heterosexist discourses (Kitzinger, 2005). Perhaps researchers cannot disrupt normative discourses at every point through their research, or in every research interaction; or perhaps they can. Regardless, it is researchers' responsibility to consider how sexual and other identities, and the (non)disclosure of these, may contribute to or constrain the production of knowledge that is useful, generative and compassionate.

There is no formula that can guide us to make a 'best' choice when negotiating sexual or other social identities and (non)disclosure in research; but there is a best way to make this

choice, and that is reflexively. The decision to disclose (or not) relevant identities that may be otherwise hidden within research interviews should be an active choice, not an omission as mine was. This requires the researcher(s) to reflexively consider the ways in which different identify positions may shape research processes during and after, and even before, the research interview. In doing so, researchers can turn toward this inescapable dilemma with a critical mind rather than turning away from this under the guise of neutrality, detachment or objectivity (Fine, 1994; Wagle & Cantaffa, 2012; Wilkinson, 1988). Indeed, identity positions do not have to be disclosed to matter; even hidden, many identity positions are not silent.

CHAPTER FOUR: "I don't think I've been asked this before": A Thematic Analysis of Participants' Conceptualisations of Sexuality and Sexual Health

4.1 Introduction

This chapter presents an analysis in relation to the first research question in this thesis: How do participants conceptualise sexuality and sexual health? It is presented in the form of a traditional chapter rather than a manuscript for publication. In the section below, I briefly explain why it is useful to ask this research question and how the analysis contributes to the broader body of work presented in this thesis. I also outline the analytic method used to generate the analysis presented below. I then present the results (section 4.2) followed by a discussion (section 4.3) in which I interpret the results against the wider relevant literature. I argue that both professional and non-professional cultural knowledge and values shaped participants' understandings of sexuality and sexual health, and then discuss how these results contribute to broader efforts to improve sexuality-related care in mental health settings.

4.1.1. Rationale and method.

As discussed in Chapter One (section 1.4.2.), little research has been conducted that explores directly how mental health clinicians understand or conceptualise sexuality or sexual health. Existing research has tended to focus on describing how mental health clinicians address or respond to sexuality and related concerns within their clinical practice or perceived barriers to doing so (e.g., Miller & Byers, 2012; Nnaji & Friedman, 2008; Quinn et al., 2011b). In the absence of clear and adequate support for clinicians in relation to sexuality within mental health settings, including a dearth of relevant professional education (discussed

in section 1.4.2.), it is unclear how clinicians conceptualise sexuality and sexual health within and across mental health disciplines. The way in which clinicians conceptualise sexuality or sexual health will shape how they respond to or address sexual concerns by delimiting or restricting what is perceived as a concern, what has caused the concern, and what (re-)actions or interventions will be most appropriate (e.g., Epstein & Mamo, 2018; Kleinman, 1980; Weeks, 2010). It is therefore difficult to fully interpret or respond to clinicians' perceived barriers to addressing sexuality or sexual concerns in the absence of a detailed understanding of how they conceptualise the phenomena in relation to which these perceived barriers act.

Many participants in the current study talked about being undertrained in relation to sexuality or sexual health. Nonetheless, they were all able to construct sexuality and sexual health and to talk about these, including in relation to their clinical practice, within the research interviews. The analysis presented in this chapter focuses on how participating psychologists, psychiatrists, and mental health nurses conceptualised sexuality and sexual health. This research question is non-specific in terms of the *context* in which participants conceptualised these phenomena. It was not possible to analyse how participants conceptualised these specifically within their clinical work, or instead beyond their work (i.e., in their non-professional lives), because of the way in which data were generated. As discussed in Chapter Two, I did not directly ask participants about their 'non-professional' perceptions or experiences regarding sexuality in order to maintain their comfort within the interview (see section 2.4.2.). Many participants did choose to talk about or refer to topics and experiences beyond their professional education and practice, but many chose not to do so, and it was not consistently possible to tease apart where participants' constructions were focussed primarily on professional or non-professional contexts.

Accordingly, in order to generate an analysis that described participants' conceptualisations of sexuality and sexual health within the interviews, I oriented to all constructions of these phenomena within and across the interviews regardless of whether participants were discussing these very broadly or specifically within their work (the latter was most common). The analysis was therefore generated both in relation to direct questioning (all participants were asked, at some point during the interview, how they understood or what they meant by the term 'sexual health': see section 2.4.2.) and participants' talk throughout the interviews (e.g., I attended to the kinds of ideas or topics that participants chose to introduce into our conversation independently or through probing, and those that were absent).

The analysis presented in this chapter was generated via critical thematic analysis as outlined in Chapter Two (section 2.5.1.). This analysis was largely inductive and descriptive. That is, this analysis was not driven by a specific theoretical approach and there was a primary focus on semantic aspects of the data, although latent aspects were also attended to (see section 2.5.2.). The analysis was nevertheless a *critical* thematic analysis because it was generated within and guided by the broader social constructionist and critical health psychological frameworks underpinning the project (outlined in sections 2.2 and 2.3). I also engage in theoretical interpretation in relation to the analysis in the discussion (section 4.3).

4.2 Results

Participants' conceptualisations of sexuality and sexual health were varied across and within disciplines. These conceptualisations focussed primarily on sexual health and could be loosely categorised into two nested overarching themes: *Sexual health is "all about sex"* (core to most participants' conceptualisations) and *Sexual health is "more than just having*

sex". A third theme, *Diverse sexualities*, captures the common understanding of 'sexuality' as sexual identity or orientation, and this cut across both nested sexual health themes.

Extracts are provided to illustrate the analysis: Words or parts of words that were stressed by the speaker are underlined; words added to improve readability are contained within square parentheses [ ]; and sections of speech removed for concision are signified by […].

4.2.1. Sexual health is "all about sex".

A central focus on (hetero-) sex[34] and the biological and physical aspects and consequences of this was common across most participants' conceptualisations of sexual health. Sex was perceived as being a normal part of experiencing adult life; something that everyone does. In relation to sex, there was an emphasis on "keeping your body <u>physically</u> healthy" (Amy, nurse), avoiding "high risk behaviours [… such as having] sex with random people" (Nick, psychologist), and having or maintaining normal "sexual functioning [… and] desire" (Fay, psychologist). Indeed, biomedical aspects of sexual health were regularly centred as the most pertinent, if not only, aspects of sexual health within participants' talk, particularly when they were talking about mental health settings or practice. Even participants who conceptualised sexual health more broadly (discussed in the second overarching theme, section 4.2.2.) often gave preference to biological and physical aspects when discussing sexual health in the context of mental ill/health and mental health settings specifically. Conceptualisations of sexual health as *all about sex* were therefore characterised

[34] When talking about "sex", participants were mostly referring to penile-vaginal intercourse between one man and one woman and, less commonly, penile-anal intercourse between two men. Participants' use of "sex" was never discernibly referring to sexual activity between two women, to other forms of penetrative intercourse (i.e., oral penetration, penetration with body parts other than the penis, or penetration with toys) or to non-penetrative sexual activities between two people of any gender. I therefore also use the term 'sex' to refer to penile-vaginal or penile-anal intercourse.

by a biomedicalised, individualistic approach and an orientation toward risk. This was illustrated neatly in one participant's response to my direct question about how they understood sexual health:

> Well I suppose there are two main prongs to that question one would be… the physical and medical side of sexuality, so you know like sexually transmitted diseases and so on. The other would be the physical functioning side of it where, you know people may have difficulties with, oh I don't know, getting an erection or premature ejaculation or not having an orgasm, or whatever. And there's probably a third prong to it too and that would be to do with paraphilias, you know paedophilia and abhorrent kind of sexual behaviour. (Scott, psychologist)

The focus on the individual and their body as the site of sexual health was further illustrated through the way that relationships were commonly perceived: Intimate relationships were the appropriate or expected spaces in which people could "have their sexual needs met" (Ben, psychiatrist). That is, relationships were understood to be related or relevant to sexual health only insofar as they provided the context in which individuals engaged in sex. Individuals' sexual lives were often constructed as existing within, but nevertheless being separate from, their relationships, as illustrated by Mia's talk below:

> There's a number of different aspects [of sexual health relevant in my work] really. I mean one obvious thing is that if people are psychiatrically unwell [then] generally their libido is affected and their relationships are affected, so often things won't be going [well] in their sexual lives just as they're not going well in their relationships. (Mia, psychiatrist)

Overall, within this theme sexual health was perceived as being related primarily to physical (biological) sexual safety and normal sexual functioning and desire. Moreover, sexual health tended to be defined or indicated by what it was not: the absence of illness and disease, unwanted pregnancy, coercion and violence; and the presence of normality (i.e., in relation to sexual functioning and desire), which was itself defined against dysfunction and abnormality. These are explored in the sub-themes below.

4.2.1.1. Sexual health as the absence of illness and risk.

Participants' conceptualisations of sexual health tended to centre biomedical aspects of this, even if they drew on or constructed more holistic conceptualisations at other points during the interview. Avoiding the transmission of STIs or blood borne viruses and unplanned pregnancy was perceived by participants as being absolutely necessary for sexual health. This was achieved through 'safe sex', the enactment of which required *knowing* about safe sex practices and *acting* on this knowledge. Safe sex generally referred to the use of condoms as a prophylactic and contraceptive, non-prophylactic contraception (e.g., hormonal contraceptives), or both. Participants emphasised the need for 'sexual health literacy', which meant having good awareness of the risks and potential consequences of engaging in sex (pregnancy and transmission of infection or disease) and appropriate knowledge, skills, or strategies for mitigating or managing that risk (i.e., by engaging in safe sex).

> You know being mindful of um… Well obviously contraception. Being mindful of- and I guess this is just getting back the young people we see you know, consent when drinking those sort of things um… If they're going to be having sex, you know being mindful of STDs [sexually transmitted diseases] and being comfortable talking to the

> doctor about it, those sorts of things […] more just primary health preventative measures […] (Dean, nurse)

Some psychologist and nurse participants talked about providing education to build individuals' sexual health literacy and help them "make wise decisions" (Nick, psychologist). While this education was mostly focussed on biological aspects of sexual health, it sometimes extended toward the need to give and check for consent and to have an understanding of "what is and what isn't ethical" or socially acceptable (Simone, psychiatrist). Consent was mostly discussed by participants within the context of 'safe sex', where it referred to a decision to engage (or not) in sexual activity based on the identification and weighing of risk. That is, consent was generally conceptualised as a decision or process that occurred alongside, and as part of, physical safety measures regarding disease and pregnancy, as illustrated by the extract below. This was occasionally accompanied by a discussion about emotional safety more broadly, invoking concerns of respect and safety beyond their physical manifestations, but this was much rarer and generally remained on the periphery of what it meant to have 'safe sex' and maintain sexual health (see section 4.2.2.).

> [Consent] means that both parties are fully aware of what's going on so they're informed. So they're aware of what they're consenting to they're in a good state of mind to consent to it so they can't be. You know… Super high on drugs or really drunk or anything like that […] and it is really around deciding whether or not you want to engage in that activity with that person at that time in that place. (Clare, psychologist)

4.2.1.2. Sexual health as the absence of sexual violence.

Sexual violence – exploitation, assault, and abuse – was perceived as a sexual health issue by all participants who spoke about it. Particularly for psychiatrist participants, sexual violence was among the things that "really come to mind" when discussing sexual health (Eric, psychiatrist). This was also an avenue through which participants who drew mainly on biomedically based conceptualisations of sexual health oriented to non-physical aspects of this. Sexual violence was generally considered to be a clear bridge between sexual ill/health and mental ill/health (i.e., the body and the mind), illustrated below, and was perceived as having a necessarily negative impact on sexual health and potentially also on mental health. Moreover, psychological trauma following experience of sexual violence was usually perceived as being a more serious consequence than potential physical harms (i.e., transmission of disease, or pregnancy).

> Well, working in [a lower socioeconomic status area] I don't have the statistics but [a] majority of the clients have had some form of abuse in the past, and a lot of times it is sexual abuse. […] So we will definitely look into how <u>that</u> experience has contributed to their functioning <u>today</u>. So understanding the relationship. (Lisa, psychologist)

When discussing sexual violence, participants were always talking about some form of coerced or forced sexual touch or penetration of the body. Thus, although participants were often very concerned about the psychological impacts of sexual violence, this violence itself was always necessarily physical. Participants did not talk about sexually oriented verbal harassment or abuse and the impact that this could have on an individual's wellbeing, including their sexual and mental health (e.g., catcalling and other forms of street harassment are usually non-physical in nature but exist along a continuum of sexual and gender-based

violence: DelGreco & Christensen, 2019; Johnson & Bennett, 2015; Kelley, 1988 as cited in Fileborn & Vera-Gray, 2017). Similarly, participants recognised that people who are gender and sexuality diverse encounter social difficulties that negatively impact their wellbeing, but they never included physical or verbal violence against these groups in their conceptualisations of sexual violence (i.e., violence perpetrated against an individual on the basis of their gender or sexuality identity, which is a form of gender-based violence: Blondeel et al., 2018).

This requirement that violence be physical and sexual(ised) to be perceived as a sexual health issue was also apparent in the common absence of domestic and intimate partner violence within participants' talk about sexual violence. For example, psychiatrist participants emphasised risk and incidence of sexual violence issues among individuals with mental illness diagnoses, and they sometimes indicated that sexual violence could be perpetrated by an individual's intimate partner. However, these participants did not also talk directly about domestic or intimate partner violence, nor did they orient to the higher rates of intimate partner violence experienced by people with mental illness diagnoses (McCann, 2003; McCann et al., 2019).

> Sometimes it's associated with concern about exploitation of patients by others in a sexual way. That might be from a partner or it might be from a non-partner, so the individual is vulnerable. Um uh we had cases where the individual is <u>probably</u> been sexually assaulted by a partner [sic] and we have to have evidence for that before we can perhaps act on it and make arrangements to enhance protection for example. (Ben, psychiatrist)

There was some ambiguity across the data as to whether intimate partner violence was a sexual health issue at all. Many participants considered domestic violence to "fit into sexual health" only when physical sexual assault had also occurred (Fay, psychologist). Sandy (nurse) shared a specific story about an individual who had been continually emotionally, physically, and sexually assaulted by an intimate partner in a domestic setting, and she did perceive this as "domestic violence". Like many other participants, however, Sandy clarified that "domestic violence doesn't always include sexual violence and sexual health doesn't always mean domestic violence [… but] there's a cross over between the two". That is, it was not enough that the violence occurred within an intimate relationship, it was also required to be physical (coerced or forced) and sexual to be considered a sexual health issue. Other participants directly positioned domestic violence outside of their conceptualisation of sexual health. For example, Jake (nurse) emphasised that staff at his workplace "screen" individuals for a range of issues and risks including domestic violence but *not* "for their sexual health". This idea was shared by many of the participants who spoke about (sexual) violence in domestic and intimate relationships and illustrates further the common understanding that sexual health is *all about sex.*

Sexual violence was often perceived as psychologically traumatising in a way that catalysed or contributed to the development of mental illness, as well as having ongoing negative impacts on individuals' mental health or wellbeing more generally. Historic sexual assault and abuse, particularly during childhood, were perceived to be a common precursor to mental distress and general dysfunction in adult life, including difficulties in emotion regulation. Nurse participants in particular shared the idea that most individuals with SMI diagnoses "have experienced sexual abuse or rape" (Yvonne, nurse). However, participants

across all three professions described regularly encountering or working with individuals who had experienced childhood sexual abuse.

> […] a lot of my patients have a lot of sexual trauma both in their childhood and in more recent relationships and it kind of gets repeated so it [sexual health], comes up in that way a lot of the time. (Emma, psychiatrist)

Only one participant did not consider childhood sexual abuse to be a sexual health issue, preferring instead to "just call it somebody who's had sexual abuse in their past" (Mia, psychiatrist). Nevertheless, Mia did perceive that a history of sexual abuse could have an ongoing negative impact on peoples' ability to engage in healthy and enjoyable sexual relationships, for example where engaging in consensual sex could "trigger flashbacks of the abuse which is really distressing". Other participants also shared the idea that a history of childhood sexual abuse could introduce difficulties to an individual's adult relationship and contribute to psychological distress by causing consensual (hetero-) sex to be distressing rather than enjoyable.

> Quite a lot of the people we see have experienced sexual trauma in childhood. Whether it be by a family member. Or a sexual assault by an unknown person. […] Some people have worked through their traumas, to different degrees with therapists […] But, then they come into more into adulthood their brains are settling down [sic] they're settling into more adult-type responsibilities [and] they may be having [intimate or romantic] relationships. And these traumas start, you know poking up again. (Sandy, nurse)

Mental distress was also seen as producing vulnerability to experiencing sexual violence. Psychiatrist and nurse participants working with individuals with SMI diagnoses

were particularly concerned that these individuals were highly vulnerable to abuse and violence, including to sexual exploitation and assault, as illustrated in the extract below. This vulnerability existed across multiple contexts including inpatient and community mental health settings, and within intimate relationships.

> **Interviewer:** Do sexual health issues come up in your work?
>
> **Jake:** All the time! All the time. And that's why I think um… Well obviously our mental health patients are the most vulnerable in terms of sexual health […] a lot of our consumers are so vulnerable they get raped and, you know obviously are too scared to tell anyone because it re-traumatises them. (Jake, nurse)

Participants' talk about vulnerability to, and experience of, sexual violence was also largely gendered and heteronormative. Participants generally perceived women as being vulnerable to and experiencing sexual violence that was perpetrated by men. Participants very occasionally oriented to the possibility that men could experience sexual violence, but this was rare and occurred mostly as a form of a self-correction during or after talking about sexual violence perpetrated by men against women.

> [Discussing women's vulnerability to sexual violence…] woman, usually- I mean it can be men too, men can be sexually assaulted definitely can be sexually assaulted. (Eric, psychiatrist)

Participants did not talk about sexual violence perpetrated against an individual by a person of the same gender, including a same-gender partner. This reflects a broader, common silence regarding intimate partner violence within non-heterosexual or same-gender relationships within health settings, relevant literature, and society more broadly (e.g., see Kulkin, Williams, Borne, de la Bretonne, & Laurendine, 2007). It is also congruent with the

perceptions within the wider overarching theme, where sexual health was primarily about *hetero*sex or penile-vaginal intercourse specifically, and sexual violence (an antithesis of sexual health) perceived as necessarily sexual and physical (i.e., where consensual sex occurs between a woman and man, then sexual violence must also occur within the same context).

4.2.1.3. Sexual health as the presence of normality.

When sexual health was conceptualised as *all about sex*, participants also emphasised the need for the presence of 'normality' in relation to sexual function and desire. Sexually healthy individuals were those who had genitalia that 'worked' to achieve penetrative and climatic sex, and who had a normal and appropriate desire for sex. This focus on physical functioning tended to be at the level of the individual even when the sex was occurring in an interpersonal context, as illustrated by Claire's talk below. Normal sexual function and normal sexual desire are discussed separately in the following sub-sections.

> **Interviewer**: Um so what would it look like if someone's <u>being</u> sexually healthy or someone <u>has</u> sexual health?
>
> **Claire**: I think that means that they would <u>function</u> in a way that would make them happy. Whatever that might be. So they have good an adequate level of functioning for whatever they desire, so if they have a partner and they want to have sex with that partner then they're able to <u>do</u> that, or if they're single and, I don't know, want to masturbate then they're able to bring themselves to orgasm I suppose. I think it's kind of just really around whatever you <u>want</u> to do and your body being able to facilitate that in whatever that looks like. (Claire, psychologist)

4.2.1.3.1. Normal sexual function.

There was an overall concern with sexual *dys*function[35] in the data, reflecting not only the centring of sex in participants' conceptualisations of sexual health but an assumption that the ability to have sex is indicative of sexual health itself. That is, sexual dys/function was often conceptualised through a biological, reductionist approach such that the absence of physical dysfunction necessarily signalled sexual health. Thus, if an individual was not or was no longer experiencing sexual dysfunction, or if this dysfunction was not prioritised highly by the individual or the clinician, then sexual health was not perceived as an issue requiring further attention in the mental health setting.

> Certainly it's [sexual health] something that we <u>do</u> enquire about and it's relevant […] And it might be that a screening question would just dispense with that immediately in terms of "do you have any problem in in relationships with your wife or husband, is there a problem with any <u>physical</u> relationship that you have with them, or any problem with your sexual function", and that might be the end of the matter. (Ben, psychiatrist)

Participants perceived that sexual dysfunction was one of the most common ways that sexual health issues arose in their work, particularly within those settings where individuals had serious mental illness diagnoses, were receiving pharmacological treatment (i.e., psychotropic medications), or both. Sexual dysfunction including difficulties with erection, lubrication, climax, ejaculation, and reduced libido[36] were understood to co-occur with

[35] I use the term sexual 'dysfunction' (rather than 'concern' or 'difficulty') to best reflect participants' language.
[36] Libido is included here because participants sometimes included this in talk about sexual dysfunction. Perceptions regarding sexual desire, normality, and sexual health are explored directly in the following sub-section.

mental distress, to be symptoms *of* mental illness, and (most commonly) to occur as side-effects of psychotropic medications.

Iatrogenic sexual dysfunction (i.e., occurring as a side-effect of psychotropic medication) was discussed by all psychiatrist and most nurse participants as "one of the more common" sexual health problems in the mental health setting (Sandy, nurse). These participants all talked about the ways that medications could "stuff up people's sex lives" (Simone, psychiatrist) by negatively impacting sexual function or desire, or both. Two psychologists talked about sexual side-effects of medication: Fay recognised this as a potentially serious sexual health concern but placed it specifically outside of her role, while Scott dismissed this as a lower priority for the individual than non-sexual side-effects or the symptoms of the mental illness being treated. Other psychologist participants' silence on this topic may have reflected their professional capacities, where psychologists are unable to prescribe medication. The general lack of recognition that psychotropic medications, including those commonly used to treat anxiety and depression, can cause distressing sexual side-effects (discussed in section 1.3.3.2.) demonstrates an unexpected silence regarding the 'biological' domain within the biopsychosocial approach to health espoused within the discipline of psychology (this is discussed further in section 4.3.3.).

Participants who spoke about iatrogenic sexual dysfunction tended to acknowledge and be concerned about the distress that this could cause for individuals and the need to address this appropriately. By recognising this distress, participants necessarily positioned sexual function as being important for many individuals. Some participants also talked about examples of men using 'Viagra' (Sildenafil) or other stimulants to address iatrogenic erectile dysfunction. Interestingly though, the responsibility for the prescription and management of

Viagra belonged to the GP and so, once identified, this sexual health issue was shifted outside of the mental health setting:

> [Individuals experiencing iatrogenic sexual dysfunction are often] very upset about it or angry about it […] So that's a huge challenge because you have to try and really minimise the impact of that side effect and sometimes it's very difficult to do that. […] some [individuals] will go out and seek stimulants like Viagra to compensate for that from their GPs and I'll recommend that to them. The GP has to start that of course and monitor that yeah. (Ben, psychiatrist)

Nonetheless, it was the potential nonadherence to medication schedules associated with iatrogenic sexual dysfunction that catalysed the relevance of this within the mental health setting. For example, Brett (nurse) was primarily interested in, and concerned about, nonadherence to pharmacological treatment and he saw this as the main way in which sexual health could become relevant in his work. He positioned this concern as being not just about maintaining medication adherence but as caring for and supporting individuals in a way that included their sexual health. Despite this, he did not talk about supporting individuals' sexual or intimacy needs beyond ensuring that medications were having the least possible impact on their sexual experiences.

> considering it's [sex is] something that everybody else does, like [something] that everybody engages with, I think it needs to be normalised so that our clients are a bit more honest and open with us [about sex]. Especially like as I said the [medication] side-effects impacting on a person's sexual health and sexual functioning, I think it needs to be sort of being able to be spoken about as a way of ensuring adherence, and if it's not working for them we can maybe find another solution so that basically their

mental illness is being treated and also not impacting on their sexual health. (Brett, nurse)

Nurse participants occasionally talked about the negative impact that non-sexual side-effects of pharmacological treatments could have on individuals' ability to engage in and maintain intimate relationships. For example, Emily shared a conversation she had had with an individual who felt that his iatrogenic night-time bed-wetting was disrupting his ability to maintain sexually intimate relationships:

> […] like you need a rowboat to get to the bed they just flood the beds. He says "yeah that's really sexy you know, have somebody in the bed with you they're going to be floating out the room". I said "oh you can't have an intimate relationship with that" or the hypersalivating I said "who's going to be attracted to that?" (Emily, nurse)

Participants rarely oriented to the negative impacts that psychotropic medications can have on fertility and pregnancy (e.g., Galbally, Snellen, & Lewis, 2011; McAllister-Williams et al., 2017). There was an underlying assumption that women rarely became pregnant or had children while receiving pharmacological treatments that "can affect foetal development" (Mia, psychiatrist), though participants occasionally commented that "we all have patients who become pregnant" (Eric, psychiatrist). Indeed, despite many participants' broader concerns regarding risk of pregnancy via unsafe sex or sexual violence, participants gave few indications that planned or continued pregnancies might occur within the context of SMI diagnoses and engagement with mental health services.

Beyond these occasional considerations of non-sexual side-effects of pharmacological treatments impacting sexuality, intimacy, and pregnancy, participants almost always focussed on sexual (dys)function when discussing how psychotropic medications can negatively

impact sexuality and sexual health. Moreover, these issues were most often discussed in relation to men's sexual dysfunction and associated distress. Participants often did not mention iatrogenic sexual dysfunction in relation to women unless specifically asked by the interviewer (myself). When this happened, participants often dismissed women's potential sexual dysfunction as being rarer and less distressing for them (compared with men). Amy (nurse) provided a very clear example of this, explaining that women could experience iatrogenic sexual dysfunction but that "it doesn't worry women quite as much because often they've had an unhappy history" (referring to experiences of sexual violence) and were therefore less interested in having sex in general. This also drew on the common perception that women are vulnerable to and have experienced sexual violence, which then causes ongoing difficulties or disinterest in intimate relationships (discussed previously, section 4.2.1.2.). Other participants, when asked, indicated that they had not considered iatrogenic sexual dysfunction in relation to women before. This was often despite assertions that they proactively enquired about or discussed these with men.

> **Interviewer:** Do medications affect women as well?
>
> **Yvonne:** I'm sure they do. But it's not something that I have ever talked to them about, have I? God… I don't think it is. I don't think <u>any</u> women have ever talked to me about how it is… That affects their… Sexual functioning… Nope. It's about sleep, some of the medications they do make them really drowsy, but no I don't think I ever have. (Yvonne, nurse)

Sexual function and, by extension, having sex was perceived as particularly important for men, and especially 'young' men. In this way, participants drew on a common, essentialist understanding of gender in which men 'need' sex (Hollway, 1984) and the ability

to experience climatic penetrative sex is therefore "understandably very important" for them (Josh, psychiatrist).

4.2.1.3.2. Normal sexual desire.

When participants conceptualised sexual health as *all about sex*, this also required 'normal' and 'appropriate' sexual desire in relation to both the level or intensity of that desire and the form or expression through which that desire was enacted. Sexual desire or expression that did not fit within proscribed norms was generally perceived as abnormal or deviant and, ultimately, unhealthy. These norms were defined against abnormality, where normal or healthy was indicated by the *absence* of abnormality or deviancy. As discussed in the preceding section, participants perceived reduced libido or desire to indicate poor sexual health and to be potentially distressing for individuals. Heightened or 'inappropriate' desire and expression was similarly perceived as indicating sexual ill-health. This was also often understood as a symptom of mental distress or illness, as illustrated in the extract below, and was generally constructed as being distressing for others and wider society as well as (potentially) the individual themselves.

> if we looked at addiction as being a sign of mental ill health, and somebody's addiction was to sex or pornography and then that made that person feel shamed [or] embarrassed and started to result in them… withdrawing from social life [or] making them even more depressed. Well yeah I'd say that there'd be that link within that [between mental and sexual health], but that makes it more of a symptom than a link I guess. (James, psychologist)

Regardless of its intensity, sexual desire also needed to be appropriate, 'normal', and 'healthy' in and of itself. A range of sexual desires and expressions were constructed within

participants' talk as being either deviant or abhorrent, where the distinction between these were the elicitation of moral concern or moral disgust, respectively. Deviant sexuality elicited moral *concern* from participants, or others about whom participants were speaking. This deviancy often included sexual desires or expressions that were understood as largely socially unacceptable such as non-traditional relationship structures, non-heterosexual identities, 'promiscuity', and engaging in sex work or transactional sex. For example, Fay (psychologist) considered herself very accepting of diverse sexuality identity and expression, but she talked about some colleagues' "lack of respect and lack of understanding of people's sexuality and, particularly, less typical choices". These less typical behaviours and choices included bisexual identities, sexual fetishes, and atypical relationship structures including non-romantic co-parenting or non-monogamous sexual relationships. These expressions were all "quite judged by some clinicians" who Fay worked with and she worried that this might be stigmatising and "stop people from disclosing things". Participants often anticipated that individuals would experience shame, embarrassment, or distress in relation to their sexual deviancy, due to either the deviancy itself or others' perceptions of it. Yvonne (nurse) oriented explicitly to the moral implications attached to many forms of sexual expression that were often considered unhealthy, inappropriate, or deviant:

> I think that, you know there's a <u>moral</u> judgement around whether that's okay or not [having 'six sexual partners a week'], but that's not my decision to make. […] It's, for <u>me</u> I'm married so it's not a choice that I'd be making. But I also don't have the right to make that moral decision for somebody else. (Yvonne, nurse)

Sexual desires or expressions that were perceived as abhorrent elicited moral *disgust*. These were perceived as particularly "ick[y]" (Fay, psychologist), and referred mostly to

paraphilias, or "desires […] that society deems inappropriate" (Sandy, nurse). Participants often talked about the difficulty or "struggle […] to maintain that level of empathy and understanding" (Fay, psychologist) when working with individuals who had talked about or acted on paraphilic, and particularly paedophilic, desires.

> […] if a therapist was seeing someone who might have for example paedophilic thoughts [then] there would be some therapists who would have emotional responses to that that are not objective or neutral. And my view is that, regardless of what you confront, that really the profession demands that there is neutrality and objectivity, and I would be concerned that there are many instances where, understandably, that might not happen" (Ben, psychiatrist)

Ben positioned this difficulty in remaining neutral when confronted by an individual who expressed paedophilic desires as being "understandable" and, therefore, a justified or even expected response despite the professional expectation to remain non-judgemental within the therapeutic encounter. Participants commonly constructed their abhorrence toward paraphilic desires and actions as a normal social response that was shared by others or society at large. Further illustrating this, Sandy (nurse) positioned her ability to work comfortably in relation to paraphilic desires or behaviours as being *uncommon*, contrasting this with other clinicians' discomfort:

> I can work with people with people with paraphilias, it doesn't bother me that much, whereas other people won't, [they] just can't handle people who are attracted to minors. […] I would say that it's not that typical a thing to be comfortable with these sorts of issues [paraphilias including incest]. A lot of people [nurses] they do have attitudes towards people that are, you know that are paedophiles, that have abused

> animals, that have raped people. Uhm… They do have attitudes that are quite, that can be quite negative and dismissive of the person… So I guess I am bit different in that way, in that I still see them as a person with thoughts and feelings just like everyone else. (Sandy, nurse)

Although moral judgements regarding 'abnormal' sexual desire and expression were often constructed as being shared, what constituted deviant or abhorrent sexuality was perceived differently across the dataset. Desires and expressions that were constructed as necessarily deviant or even abhorrent by some participants, or by those about whom they spoke, were dissimilarly perceived as relatively acceptable or available choices by other participants. This was illustrated in Fay's (psychologist) acceptance of non-traditional relationship structures despite her colleagues' discomfort with these, discussed above. Abhorrent sexuality was also constructed differently across the dataset. Scott (psychologist) abhorred the practice and pornographic depiction of BDSM[37] and considered this antithetical to sexual health, placing it in the same category as child sexual abuse[38]:

> There's also a lot of really bad porn, like child pornography I've never looked at it thank god but that and some S and M stuff. It's not healthy, it's not sexual health that's for sure! [… because] it portrays things in a… a… it, it portrays things as normal that aren't normal. You know and that, I'm not expressing it very well but uh… it portrays stuff that… um… Is wrong. Yeah. I don't know how else to put it. You know, some people might say disgusting or, but you know… It's, I just don't think it's healthy. At all. You know. And I don't know I've never viewed S and M

[37] Bondage and discipline, domination and submission, and sadomasochism.
[38] All participants considered sexual assault, including child sexual abuse, to be unacceptable behaviours, as do I. My analytic interest here is in exploring how these and other sexual behaviours, desires, or expressions were positioned as being acceptable, deviant, or abhorrent; and how this positioning shifted across the dataset.

either but I… I suppose some people like getting hurt but to me it's not a natural thing to hurt people… It's yeah it's wrong. Yeah." (Scott, psychologist)

Simone (psychiatrist) also explained that "pain is one of the big reasons for [people] not enjoying sex", particularly in the context of chronic pain experiences. In contrast to Scott's talk, however, she commented simply that some people nevertheless experience (sexual) pleasure in pain since they engage in BDSM, and did not construct this as inherently healthy or deviant. Sandy (nurse) similarly commented that she had encountered people who "enjoy the BDSM scene" but that she had "no issue" with this because she understood that it is consensual (i.e., not coercive or forced). Indeed, all participants' conceptualisations of sexual health included boundaries regarding what could be perceived as un/acceptable or un/healthy sexual desires, expressions, and behaviours. Where these boundaries were positioned, and what kinds of social or emotive response was legitimated by transgression of these, were not static across the dataset.

4.2.2. Sexual health is about "more than just having sex".

Although sex and the biomedical and physical aspects of this were a cornerstone of most participants' conceptualisations of sexual health, many participants constructed sexual health as being about "more than just having sex" (Yvonne, nurse). Within this broader conceptualisation, sexual health was expanded beyond concerns with safe sex and sexual function to incorporate being "comfortable and confident" with oneself and one's sexual, intimate, and romantic experiences (Gale, psychologist). Some participants explicitly conceptualised sexual health as a sense of wellbeing that expanded from sex to sexuality more broadly:

> I think it's [sexual health is]… it's a bit like physical health and spiritual health, and mental health. It's uh… it's a sense of wellbeing, a sense of wholeness, a sense of things being as they should be to the individual. Being comfortable, feeling safe, being happy. They're the sort of features of sexual health for me […] probably a sense of wellbeing I think would be a strong feature for me in describing that. (Jeffrey, psychologist)

Not all participants who constructed sexual health as *more than just having sex* explicitly discussed or referred to the need for a sense of wellbeing. Nevertheless, many participants tended to construct sexual health in a way that expanded beyond sex and a narrow focus on the individual and their body, though these broader conceptualisations were often difficult for participants to fully articulate. Several sub-themes captured these broader constructions: Sexual health extends to intimacy, relationships, and emotional safety; Sexual health extends beyond the individual; Sexuality as a "sense of self"; and Sexual health is different for everyone.

4.2.2.1. Sexual health extends to intimacy, relationships, and emotional safety.

Intimacy, relationships, and emotional safety were some of the defining features of a conceptualisation of sexual health as *more than just having sex* overall; though not all participants who constructed sexual health in this way included or talked about each of these notions. Intimacy was often conceptualised as being a part of sexual health, particularly by nurse participants. Intimacy was perceived as a sense or feeling of connection with others and therefore related to, but as more than *simply*, sex and sexual expression. Intimacy, as it related to participants' broader constructions of sexual health, could be physical and sexual, physical and nonsexual (e.g., including "touch, cuddles, physical contact": Lisa,

psychologist), or emotional and non-physical. Moreover, intimacy was perceived as being an important experience for people, including those with mental illness diagnoses, as illustrated by the extract below:

> [Intimacy is about] the human connectedness. […People with schizophrenia diagnoses] find it very difficult to have conversations with people let alone become intimate with it and [experience] the emotional connection […They say that] they feel truly connected […] when they're on amphetamines and they would rather risk a psychotic episode than give up the amphetamines. Because they feel connected. (Emily, nurse)

While participants perceived that it was possible to be intimate without sex, 'good' sex tended to be conceptualised as involving intimacy, or a "connection" between two people (Dean, nurse). Indeed, intimacy was usually discussed within in the context of (monogamous) dyadic relationships, and the ability to engage in and maintain such relationships was positioned as contributing to, and indicating, sexual health: "in terms of intimate relationships sexual health is an important part of that" (Claire, psychologist). Moreover, relationship difficulties could impact on sexual health by reducing the level of (desired) intimacy including sexual intimacy. This contrasted with the way that relationships were positioned as the context or site within which sexual health might be performed or achieved when it was constructed as *all about sex* (see section 4.2.1.). Participants who perceived that relationships were part of sexual health were mostly psychologists and nurses; psychiatrist participants tended not to emphasise a need for intimacy nor include intimacy within their conceptualisation of sexual health.

Emotional safety was also perceived as contributing to sexual health. This was related to consent as a decision process that helped to maintain physical safety in relation to safe sex and sexual violence (discussed in section 4.2.1.1.); however, when participants talked about consent in relation to emotional safety there was also an emphasis on respect and communication. That is, "emotionally safe" sexual expression necessarily included physical safety from violence but *also* required that sexual interactions and relationships were respectful and "validating" (Josh, psychiatrist) in a way that was nurturing and flexible. While all participants who spoke about the need for emotional safety also spoke about the need for physical safety, the reverse was not true. Participants who talked about emotional safety were mostly psychologists, sometimes nurses, and only occasionally psychiatrists.

> […] when we're talking about sex between two people it is really around consent… communication and making sure that everyone's on board with what's happening and being able to feel comfortable with say[ing] 'I don't like this, I don't want this to happen', you know 'this is not cool, not on' […] actively listening for that and engaging the sexual partner around it. Are they okay with what's happening, you know are you treating them with respect. (Nick, psychologist)

4.2.2.2. Sexual health extends beyond the individual.

When participants constructed sexual health as *more than just having sex,* they necessarily acknowledged or oriented to the interpersonal nature of sexuality and sexual expression, rather than situating sexual health within the individual as if isolated from and independent of others. That is, within this conceptualisation, sexual health was not just about the individual and their body. Participants acknowledged and discussed the ways in which individuals interact with others regarding, or in the context of, sexuality, sexual health, and

sexual expression at the level of intimate and sexual relationships, families, communities, and society more broadly. For example, some participants talked about the distress that iatrogenic sexual dysfunction may cause within individuals' intimate relationship(s) and for their partner's sense of confidence and self-worth related to their sexuality; particularly if the partner (or the individual) lacked a full understanding as to why the sexual relationship had changed. Gale (psychologist) regularly worked with families whose child/ren have sleep problems and reflected that the "sexual health of [those] families" is likely to be "fairly minimal" and could benefit from additional support. Some other participants similarly oriented to sexual health concerns as they occurred in the context of families and communities, as illustrated below:

> I've had a number of predominantly men with frontotemporal dementia who I've looked after [and] who present with various sexually disinhibited behaviours and that's very difficult for their families to cope with, it's very difficult for other patients on the ward to cope with. And it's a difficult problem for managing them in the community, say in a residential aged care setting. […] it kind of brings issues of sexuality… uncomfortably into a domain where people are having to interact with it […] (Josh, psychiatrist)

As illustrated above, some participants perceived that aspects of an individual's sexuality or sexual health can impact on that of others. Participants also discussed the ways in which an individual's sexual health may be impacted (positively or negatively) by interpersonal or social factors including social norms and values, or by the choices, desires, preferences, and (dis)comfort of others. For example, participants commonly described familial and social difficulties associated with sexuality and gender diversity which could

negatively impact on how individuals felt about themselves and, consequently, their mental health or wellbeing. One participant, Sandy (nurse), also talked about the interpersonal difficulties that people may experience, including shame and ostracism, as a consequence of sexual desires and preferences that are not considered normal or appropriate by society (i.e., 'paraphilias').

Although participants' talk tended to move easily between individual and interpersonal conceptualisations of sexual health, the latter was much less common both across and within interviews. Accordingly, an understanding of sexual health that encompassed interpersonal contexts including relationships, families, and broader localities or communities was rarely participants' foremost thought within interviews (i.e., this construction was built up or drawn on through deeper reflection and conversation within the interview). There were just a few exceptions to this pattern, including Gale (psychologist) who, when conceptualising sexual health, thought first of intimacy and connection and later of reproduction and safer sex.

> [Sexual health is] anything that's related to one's sexuality- and then when you ask that question I think well, you know I guess IVF [invitro fertilisation[39]] and pregnancy is pretty related to that so maybe I see a lot of that [sexual health-related issues]. But I guess I was thinking of it more in a… you know a… sexuality and intimacy kind of way. Yeah. But then now I think, you know I think probably IVF probably comes under the same banner […] (Gale, psychologist)

[39] IVF is an assisted reproductive technology.

4.2.2.3. Sexuality as a "sense of self".

Sexuality was conceptualised in different ways across the data. Some participants, particularly those who constructed sexual health as *more than just having sex* (i.e., psychologists and nurses), constructed sexuality as a broader *sense of self* that incorporated sexuality and gender identity as well as sexual expression, desires, preferences, and relationships. Within this conceptualisation, sexuality referred not only to sexual identity or orientation and choice of sexual partners (this narrower but common conceptualisation is discussed in section 4.2.3.) but also to how people relate to themselves and others. Accordingly, "knowing what you like" (Emma, psychiatrist) and being "comfortable" in oneself (Brett, nurse) and in one's "own sexuality" (Sandy, nurse) was inseparable from sexual health and wellbeing more broadly.

When sexuality was conceptualised as a *sense of self* in relation to sexual health, then how people feel about themselves, including their self-esteem and self-worth, was also understood as an aspect of sexual health. Sexuality and sexual health were perceived as being intertwined, where problems with one could negatively impact the other. For example, psychological trauma resulting from experiences of sexual violence could impact individuals' self-worth and ability to conceptualise intimate relationships that were safe and nurturing. Some participants who spoke about working with individuals with these kinds of experiences also emphasised the importance of those individuals gaining a sense of empowerment or "control" over their body (James, psychologist), sexuality, and sexual expression, as illustrated below.

> [When addressing clients' historical sexual trauma] it's been more about kind of looking at what is this [current] pattern of behaviour […] so it's I guess not so much

> about the sexual behaviour ["promiscuity"] it's really more about, you know their sense of self and confidence, and the idea that they're broken is what comes up a lot, you know this is the only way that they know how to do it [intimate relationships]. So I guess it's kind of more changing the understanding about where that comes from and therefore letting them kind of take charge of what they want to do rather than feeling like they have to do something in particular. (Gale, psychologist)

Similarly, physical or biological sexual health concerns could negatively impact sexuality as *sense of self.* A few participants talked about how iatrogenic sexual dysfunction was a problem for individuals' sexual health not only in terms of sexual function itself but because this could negatively impact their sense of self. For example, if a man's erectile or ejaculatory function was impaired then this could negatively impact "how he viewed himself and his potency and his masculinity" (Emma, psychiatrist). Sandy (nurse) also talked about how sexual dysfunction could impact on how a man viewed himself as both a man and a sexual being, illustrated below. It is noteworthy that only men's sexuality was discussed directly in this way. This reflects the broader gendered approach to sex, sexual expression, and sexuality in the data (e.g., see sections 4.2.1.2; 4.2.1.3.1.).

> […] so some of the medications that are given can cause erectile dysfunction or premature ejaculation, um a lot of time with depression and anxiety there is low libido. And what comes with that is the questioning of the person themselves it's like sometimes it can go back to their identity. If it's a male with erectile dysfunction they feel like they're not as they're not as much of a man as they should be. (Sandy, nurse)

Participants who conceptualised sexual health as *more than just having sex*, including within the mental health setting, tended to position sexual expression and identity as "a really

important part of people's lives" (Fay, psychologist). Even where these participants talked about the importance of 'sexual function' in the context of sexuality, they tended to perceive this as a mode of expression of sexuality, identity, and self, rather than positioning sexual function or sex as a (biological) need in and of itself (contrast this with section 4.2.1.3.).

> Well I suppose I'm someone who thinks that health is a holistic thing and for most people sexual expression and… sexual identity, and I don't just mean gender identity but um… is a part of who we are as human beings […] People feeling comfortable or… satisfied around their sexual health or their sexual expression is also important and I just think if you try and deny any part of yourself it's not healthy. You know, it has impact. (Lucy, nurse)

A few participants – and they were only nurses – emphasised the inseparability of sexuality and sexual health from other aspects of health care. They conceptualised these not only as an important part of human experience but as part of the whole person, illustrated below.

> **Emily**: [… sexuality and sexual health concerns are] part of life. I don't care if they talk to me about it.
>
> **Interviewer:** Is it a part of your job?
>
> **Emily**: Yeah I think so because again you're looking at the whole person and how they feel about that does impact on their mental health and physical health. (Emily, nurse)

4.2.2.4. Sexual health is different for everyone.

Participants who conceptualised sexual health as *more than just having sex* often struggled to define it in specific terms. That is, although everyone agreed that illness and

violence were antithetical to sexual health, participants whose conceptualisations of sexual health expanded beyond the absence of 'ill-health' often struggled to define or identify positive aspects of health. Some participants found the question 'what is sexual health'[40] challenging in itself:

> **Interviewer:** […] What do you mean when you're talking about sexual health?
>
> **Sandy**: Okay. I don't think I've been asked this before let me try and formulate it. Uhm. For me sexual health means that a person… Is able to… That a person… Oh goodness. Erm… A person's sexual health is very individual. And [for] a person to have good sexual health is [it means] that they're able to, fulfil their sexual needs in a way that is, consensual. And non-harming to themselves and other people. Does that make sense? (Sandy, nurse)

Sandy went on to discuss the need to be "comfortable" with and able to "express ourselves in a way that doesn't cause physical or psychological damage", especially where a person's sexual attraction may be "outside the norm"[41]. That 'expression' was necessarily ill-defined, however, and took various forms throughout the interview depending on the specific experiences and contexts that she was talking about. Other participants became similarly stuck at the idea of sexual health as "feeling comfortable and confident in […] yourself and your experience and what you want" (Gale, psychologist). These notions of the need for comfort, self-knowledge, and even a "sense of wellbeing" (Jeffrey, psychologist) for sexual health were often at the very edges of participants' conceptualisations that, unbound by a

[40] This question was posed to all participants at some point during their interview, either as a direct question early in the interview or as a clarification after already talking about 'sexual health'. This depended on the flow of each interview and how much direction each participant wanted (or allowed) from me as interviewer.
[41] Sandy was comfortable working with people who had expressed or acted on paraphilic, including paedophilic, desires. However, in this instance she was referring to same-sex attraction, objectphilias, and BDSM. These forms of sexual attraction and expression may be "outside the norm" and considered deviant by some but are not (strictly) prohibited within current legal frameworks in Australia.

biological reductionist approach that defined sexual health by the absence of ill-health, were unavoidably nebulous. This allowed participants to construct sexual health in a way that was broad and non-prescriptive: It was *different for everyone* in that each person was able to define for themselves what sexual health meant and how this was achieved or experienced. Nonetheless, this nebulosity also created difficulties for participants in articulating what those positive aspects of sexual health could be. Emma (psychiatrist) summarised this well:

> See it's funny, it's like mental health, it's really… I find it [sexual health] hard to define because I… Yeah I think there's this idea that health is absence of disease but I don't think that's true. I think that's part of it. […] but I think health… has to do with… a bigger picture […] I think a big part of sexual health is knowing yourself and what you want and knowing that that can change over time too, so being able to kind of review that and explore that and look at it further. Um so you know the physical problems are kind of easy to point out and say that's part of it but I think there's a bigger bit to do with understanding and identity and desire and all of that. (Emma, psychiatrist)

4.2.3. Diverse sexualities.

There was acknowledgement of and discussion about diversity in identity, preferences, desires, and choices away from (hetero-) sexual norms across the data. This diversity included non-heterosexual identities (and non-normative gender identities[42]), non-normative practices including non-traditional relationship structures (e.g., non-monogamy), and non-normative sexual desires or interests (e.g., BDSM). When participants talked about

[42] Sexuality and gender identity are not mutually deterministic, but I discuss gender identity here because many participants tended to conflate these in their talk. This conflation is congruent with essentialist understandings of sexuality identity as determined by biological sex and heterosexuality as normal (Johnson, 2015).

'sexuality' they were most often referring to sexuality identity (or orientation), rather than to broader practices, preferences, and choices in relation to sexuality (this less common, broader conceptualisation of sexuality was discussed in section 4.2.2.3.). Accordingly, participants most often talked about non-heteronormative sexuality identities in relation to sexuality diversity.

Most participants understood sexuality (and gender) identity as being at least related to, if not a part of, sexual health (regardless of how they conceptualised sexual health more broadly). This position was not unanimous, however, and a few participants conceptualised sexuality and gender identity as being specifically separate from sexual health. These participants also tended to give primacy to biomedical aspects of sexual health such as safe sex:

> I just think someone's experience of their sexuality is very distinct from their experience of their gender. And I would say that, no matter what your sexuality or your gender experience is, everyone has, we're- you know, education around sexual health is very important and I would say that that's probably very separate. (Nick, psychologist)

Others perceived sexuality and gender identity as being related to sexual health. For some of these participants, concerns related to sexuality (and gender) *diversity* was the only time that their conceptualisations of sexual health expanded from a focus on biomedical and physical aspects of sex specifically. Positioning sexual identity and sexual health as being related did not necessarily broaden a participant's conceptualisation of sexual health away from a focus on sex, however, as Jake's talk demonstrated:

> […] my understanding is that anything to do with sex has got to do with sexual health and sexuality really because… I mean sexuality is how somebody identifies in terms of uhm which sexual partners they like to choose, and then that also has an impact on their sexual health because [of] whether or not they're going to be safe or not safe, or engaging in risky behaviours because they've taken substances or because they've got a mood disorder. I think it all sort of ties in. (Jake, nurse)

Jake perceived that sexuality (as identity) was ultimately *all about sex*, and this was why it was related to sexual health. Nevertheless, at other times during the interview he oriented to and discussed the social difficulties commonly associated with non-heteronormative sexuality and gender identities which could contribute to or exacerbate mental distress. Indeed, part of his interest in participating in the research was "because we've had this massive influx of people who were coming in because they were suicidal, on the background of their [non-heterosexual] sexuality and the fear of not being accepted by their family or by their community" (Jake, nurse). Non-heterosexual identities, and the personal and social difficulties associated with these, were the most common way in which sexuality was discussed by participants within the context of sexual health and the mental health setting. Many participants understood sexuality diversity as something that could be difficult to come to terms with (presumably in a heteronormative society) and that could contribute to or exacerbate mental distress. For young people especially, sexuality and gender diversity were perceived as a common contributor to acute distress and suicidality presentations in acute settings:

> [In the emergency department] you're seeing people in crisis and that can happen for obviously a vast number of reasons but in a young person in particular if they're

> suicidal and it's not really sure how [then] it's <u>really</u> important to ask about sexuality, sexual orientation, their identity, their gender identity all of that sort of stuff. (Emma, psychiatrist)

When sexuality diversity did not cause obvious distress or when there was no perceived diversity (i.e., where individuals identified as heterosexual and cisgender, and practised monogamy) then sexuality and sexual identity were discussed much less often. In this way, participants commonly reinforced the 'normal', and presumably healthy, status of heterosexuality and monogamy by omission through positioning these the defaulted, silent positions from which they talked about sex and sexual health (Kitzinger, 2005).

4.3 Discussion: Conceptualisations of Sexuality and Sexual Health as Cultural Knowledge

This study explored how mental health clinicians from three disciplines working in Australian contexts conceptualised sexuality and sexual health within qualitative interviews. Limited previous research has explored how health clinicians conceptualise sexuality and sexual health. This includes research confined to mental health nursing in a different geographical and cultural context (Ireland: Higgins, 2007b) and research with clinicians from several disciplines working in a different health context within Australia (doctors, psychologists, and nurses working in oncology: Ussher et al., 2013). Other relevant research with Australian mental health settings has tended to be confined to a single discipline (mental health nursing) and service, and to focus on how those participants approach or respond to, rather than conceptualise, sexuality (Quinn, 2013; Quinn & Happell, 2015a-c, 2016). This study therefore makes a novel contribution to the wider literature by providing a rich description of how mental health clinicians from three disciplines – psychologists,

psychiatrists, and mental health nurses – working across multiple settings within an Australian context conceptualise sexuality and sexual health. The results are summarised below, followed by a critical discussion in relation to the wider literature.

4.3.1. Summary of the results.

There was variation in the way(s) that participants conceptualised sexuality and sexual health, both within and across disciplines. These were captured in two overarching, nested themes. Conceptualisations of sexual health that were *all about sex* were biomedical, individualistic, and risk-oriented. These were also characterised by a reductionist approach, where sexual health was defined by the absence of *ill*-health, *dys*function, and *ab*normality (Fuller, 2017; Irwin, 1997). This conceptualisation was the most common and tended to be core to most participants' understandings, regardless of whether they also conceptualised sexual health in a broader more holistic way at some points during the interview.

When sexual health was conceptualised as *more than just having sex,* it referred to a broader sense of wellbeing that and tended to include intimacy, relationships, and emotional safety. Within this conceptualisation, sexuality was understood as a *sense of self* that was broader than only sexual identity or orientation. This holistic conceptualisation of sexuality and sexual health necessarily expanded from an individualistic and reductionist approach to include the presence of positive aspects, which is more aligned with the WHO (2006) definition(s) of sexual health and sexuality, for example. However, participants had difficulty in articulating sexual health within this broader context because it was perceived as being *different for everyone*.

Across the data, when participants talked about 'sexuality' they were most often referring to sexual identity or orientation. When used in this way, sexuality was mostly

understood as being related to, if not part of, sexual health (regardless of how participants conceptualised sexual health). Importantly, participants tended to only discuss sexuality (as identity) when there was diversity away from the hetero-norm. This positioned heterosexuality (and some other normative practices such as monogamy) as the silent norm by omission (Kitzinger, 2005). This pattern was captured in a third overarching theme, *Diverse sexualities*.

Mental health clinicians are embedded in sociocultural, professional, and personal systems of meaning that are shaped by and reinforce specific values, norms, and behaviours (Kleinman, 1980; Lupton, 2012), including in relation to sexuality. The results of this study suggest that participants' conceptualisations of sexuality and sexual health were embedded at all these levels. Most participants across all three disciplines drew on common cultural discourses of sexuality and gender to construct and make sense of sexuality and sexual health within the interviews (e.g., understanding sexuality as sex). There was also notable variation in conceptualisations between disciplines (primarily psychiatrist and psychologist participants) indicating that discipline-specific knowledge or approaches may have contributed to shaping participants' conceptualisations of sexual health. Variation within and across disciplines, however, indicates that participants also drew on non-professional knowledge and experiences in making sense of sexuality and sexual health. In the next three sections, I discuss these points in turn.

4.3.2. Consistency across the data: Sexuality as gendered, normative *sex*.

The participants in this study drew on a range of common cultural discourses of sexuality to construct and make sense of sexuality and sexual health within the interviews.

These were the ‘coital imperative’ (McPhillips et al., 2001) and gendered and heterosexist understandings about sexuality (Barker et al., 2018; Hollway, 1984).

Sexual health was most commonly conceptualised as being *all about sex*, and there was a primary concern regarding the physical consequences of, or the ability to engage in ‘normal’, sex. Moreover, sex was primarily positioned as being between a woman and a man (i.e., heterosex) or, at least, as involving an erect penis. This was demonstrated, for example, through the common focus on condom-use as a critical aspect of safe sex (and therefore achieving sexual health). Within this overarching theme, sex was also seen as a normal part of adult life, particularly in relation to romantic (monogamous) relationships. This approach to sex within the data, where it was understood specifically as penile-vaginal or (less commonly) penile-anal intercourse *and* it was mandated as part of a ‘normal’ life that includes romantic relationships, reflects common cultural discourses that are circulated, for example, through sex therapy manuals and the wider popular media (Barker et al., 2018). Together, these sexual and coital imperatives position disinterest in sex as specifically abnormal (e.g., there is no space for asexual identities or experience) and delegitimise romantic relationships where (hetero)sex does not occur (regardless of whether the individuals engage in other sexual behaviours or expressions: See Barker et al., 2018; McPhillips et al., 2001).

Other studies that have explored health clinicians’ understandings of sexuality have also reported that participants draw on and reproduce a coital imperative. In a grounded theory study that explored how mental health nurses in Ireland respond to sexuality within their work, Higgins (2007b) reported that the participants had learned to understand sexuality as *sex* (and taboo) in their early life and schooling. Moreover, this conceptualisation was not

challenged or broadened by their professional education but, rather, was reinforced or further medicalised through a focus on pathology and dysfunction. Accordingly, nurses in Higgins' study oriented to sexuality within their professional practice through largely medicalised discourses.

Participants in this study did not construct sexuality or sexual health through only medicalised discourses, though there was a dominant focus on biomedical aspects or domains. The wider range of conceptualisations of sexual health reported in this study reflects a discourse analytic study that explored how doctors, nurses, psychologists, and other clinicians working in Australian oncology settings constructed sexuality and talked about orienting to sexuality post-cancer within their practice (Ussher et al., 2013). Ussher and colleagues (2013) reported that participating clinicians constructed sexuality in "physical, psychological and relational terms" (p. 1378), drawing on both biomedical and psychosocial discourses to position sexuality as relating to physical function or to psychological and relational factors including intimacy, respectively. Like participants in this study, participants in Ussher and colleagues' study did construct sexuality as relating to wellbeing and a person's broader sense of self or identity (i.e., as *more than just having sex*). Nonetheless, and also similar to the results presented here, "constructions of sex as a physical act, defined within a coital imperative… were predominant" throughout participants' talk, reflecting a dominant 'heterocentric biomedical discourse' (Ussher et al., 2013, p. 138). Thus, in spite of disparate health settings, clinicians participating in both Ussher and colleagues' study and this one appear to construct sexuality and sexual health similarly by drawing on common cultural discourses including the coital imperative. While this might be somewhat reasonable, if incomplete, within a medical (oncological) setting such as that in Ussher and colleagues' study, a medicalised and biocentric construction of sexuality is misaligned with, and therefore

noteworthy within, a mental healthcare context that is purportedly characterised by recovery-oriented and person-centred approaches such as that in the current study (as discussed in sections 1.3 and 1.3.2.).

Participants in this study drew also on common gendered and heteronormative assumptions throughout their talk, reflecting patterns reported in other studies across health settings. Regardless of whether the participants agreed or disagreed with gendered and heterosexist assumptions about sexuality, they were complicit in reinforcing and reproducing these in their talk (also see Higgins, 2007b, p. 243). Participants' talk commonly reproduced essentialist gender stereotypes that position women and men as sexually passive and active, respectively. This was illustrated, for example, through a focus on men in relation to iatrogenic sexual dysfunction and an absence of concern about how the same medications may impact women's sexuality. Nurses in Higgins' (2007b) study similarly reported that woman rarely raised iatrogenic sexual dysfunction compared with men, and justified this by positioning women as sexually passive and men as 'needing' sex and sexual pleasure (a pleasure that must centre on an erect penis). Similar findings have been reported in a qualitative study with Australian mental health nurses (Quinn et al., 2012).

The results reported in this and other studies, discussed above, demonstrate the pervasiveness of the male sex drive discourse (Hollway, 1984) where sex is understood as a biological need for men, and their masculinity is reified through (hetero-) sexual desire for, and pleasure achieved through, sexual intercourse. This pattern was identifiable in participants' talk even when they conceptualised sexual health as being *more than just having sex*. For example, some participants who constructed sexuality as a *sense of self* positioned men's sense of masculinity as being connected to or dependent on their sexual function

(erection and ejaculation). Participants in Ussher and colleagues' (2013) study similarly positioned sexual dysfunction as disrupting or impacting *men's* identity and sense of masculinity. In contrast, changes to the sexual body post-cancer were positioned as negatively impacting women's body-image and not their sexual function and sense of femininity (Ussher et al., 2013). In the current study, negative impacts of medications or illness experiences on women's sexuality beyond concerns about pregnancy or sexual violence were rarely discussed. Femininity and sex or sexual desire were not connected within participants' talk; but men's sexual desire and function were integral components of their masculinity.

Finally, the results also demonstrate that participants drew on common heterosexist assumptions to make sense of and talk about sexuality and sexual health. Heterosexism occurs when heterosexuality is positioned as normal, natural, and requiring no explanation (e.g., Peel, 2001). Participants in this study reinforced heterosexism by omission through positioning heterosexuality and heterosexual (and monogamous) relationships as the silent, or invisible, norm within their talk (Kitzinger, 2005; Peel, 2001). They did this in two main ways. First, by explicitly orienting to non-heterosexual and other non-normative sexualities or expressions as exceptions within their talk, but rarely orienting toward heterosexuality (or monogamy) in any explicit way. Second, through drawing on the common assumption that 'sex belongs in relationships' (discussed in section 4.2.1.). Since participants commonly understood sex as heterosex, the notion that sex belongs in relationships immediately positions those relationships as being between a (cisgender) man and a woman[43], unless otherwise specified.

[43] This is a relationship structure that tends to be perceived as indicative of heterosexuality, even if the individuals involved do not identify as straight/heterosexual (e.g., Morgan & Davis-Delano, 2016)

The notion that relationships are the appropriate space or context in which sex should occur – where it is assumed that people in relationships will be having sex, and those not in relationships may not be having sex – also reflected hierarchical normative standards that position monogamous (hetero-) sex as more normal, and therefore legitimate, than non-monogamous sexual contexts or experiences (e.g., non-monogamous relationships; romantic relationships that do not include sexual expression; or casual sex: Barker et al., 2018; Rubin, 1984). The assumption that a person's relationship status also indicates whether they are sexually active appears to be common across health settings. For example, Ussher and colleagues (2013) reported that relationship status contributed to their participants' decision to raise discussions about sexuality post-cancer with patients, where this was often only perceived as important if the patient was involved in a long-term (presumably monogamous) romantic relationship.

Overall, participants in this study drew on a range of pervasive cultural discourses of sexuality and gender to talk about and make sense of sexuality and sexual health. These constructed normal or healthy sexuality within narrow and prescriptive boundaries that positioned heteronormative, monogamous sex as the most normal, natural, and healthy. These constructions were ubiquitous across the data despite many participants' talk also broadening at times to include wider aspects of sexuality and more flexible opportunities for sexual expression. The coital imperative is a powerful sexual norm (Barker et al., 2018; McPhillips et al., 2001). In order to open alternative discourses or ways of approaching and responding to sexuality within mental health settings, clinicians need to be supported to identify, understand, and critique prevalent normative sex standards that shape their current understandings. This could facilitate a "multiplicity of discursive possibilities" for imaging and responding both to hetero-sex broadly (McPhillips et al., 2001, p. 239) and to sexuality

within the context of mental distress and mental illness diagnoses. This will be explored further in Chapter Eight.

4.3.3. Variation between disciplines: Professional culture and systems of meaning-making.

Participants' conceptualisations of sexuality and sexual health were not bound by discipline. There were some important differences between disciplines, however, in the extent to which biological and physical aspects of sexual health were given precedence over psychological, social, and cultural aspects. Overall, psychiatrist participants were more focussed than psychologist participants on sex and biomedical aspects of sexual health, and this was a defining feature of their talk as a group[44]. Although both groups constructed and relied on notions of sexual health as *all about sex*, psychiatrist participants tended to centralise these aspects and expanded from these less often. In the context of serious mental illness diagnoses especially, psychiatrist participants commonly positioned biomedical and physical issues in relation to sex and sexual functioning as being related to sexual health, while interpersonal and psychological aspects of sexuality, desire, and sexual expression were perceived instead as sexual symptoms of, or issues associated with, the mental illness diagnosis.

In contrast, nurse participants' conceptualisations were the most nebulous of any of the three disciplines. Some nurses' conceptualisations were almost entirely biomedical while others' were extremely holistic. Many nurses drew on different conceptualisations depending on the specific context of the discussion at hand[45]. Regardless of how holistic their

[44] There were exceptions to this pattern within both the psychiatrist and psychologist groups, but this broad pattern was an interesting feature in the data.
[45] All participants did this, but it was most pronounced in the data generated with nurse participants.

conceptualisations were, nurse participants commonly returned to the idea that sexual health is *all about sex* when talking about this in the context of mental distress or mental health settings specifically. This was reflected in the emphasis commonly placed on biomedical aspects and physical functioning regarding sexual health over and above broader aspects including intimacy, relationships, and sexuality as a *sense of self* within the context of mental health settings and clinical practice.

These broad differences between disciplines in conceptualising sexuality and sexual health may reflect participants' professional cultures. As professions, health-related caring disciplines have their own cultural values, norms, and behaviours. Becoming a professional occurs through processes of acquiring and internalising, and therefore reproducing, the relevant profession's cultural values, norms, attitudes, and behaviours (Hafferty, 2008). From a social constructionist perspective, 'inculcation' into any culture, including a health profession, occurs through ongoing tacit and explicit processes during professional education and practice (see Clouder, 2015; Emmerich, 2015). To become a member of a profession is thus to be taught, or inculcated into, ways of *being* and *thinking* like other members of that profession, or culture. Thus, a discipline's dominant epistemological perspectives, paradigms, or modes of thinking are learned and come to be reproduced by clinicians within that profession[46] (Emmerich, 2015). These modes of thinking are supported by and reinforce broader discipline-specific clinical realities, or "explanations and value statements about…illness" including what causes the illness and how to treat it (Kleinman, 1980, p. 99).

[46] These processes are not entirely deterministic (Clouder, 2015); a social constructionist approach to inculcation as put forward by Bourdieu and expanded by Emmerich (2015) allows for individual agency in the reproduction (and modification or rejection) of cultural norms, values, and behaviours.

Clinical realities guide clinicians in understanding and approaching both familiar and unfamiliar health- and illness-related phenomena within their clinical practice.

As medical doctors, psychiatrists are inculcated into a biomedical approach to health that is largely individualistic, risk-oriented, and reductionist (Engel, 1977; Fuller, 2017). In Australia and New Zealand, the discipline of psychiatry purports to take a recovery-oriented, evidence-based, biopsychosocial approach to mental health and illness (The Royal Australian and New Zealand College of Psychiatrists, 2016). Despite this, psychiatric practice and research in Westernised societies continues to privilege biological dimensions of mental illness over and above the psychosocial (e.g., Cromby et al., 2013; Priebe, 2016). This is aligned with the discipline of medicine more broadly. Indeed, psychiatrists are "medical doctors who […] specialise in diagnosing and treating people with mental illness" (The Royal Australian and New Zealand College of Psychiatrists, 2017). In this study, this was reflected in the way that psychiatrist participants commonly drew on biomedically informed explanations and justifications for why particular aspects of sexual health were more relevant to their practice, even when they did orient to broader aspects of sexual health.

The discipline of psychology also claims to take a biopsychosocial perspective toward mental health and illness but there is evidence that, in practice and research, these domains are not properly integrated (e.g., see Crossley, 2008) and psychological aspects of (mental) health are privileged over both biological and social aspects (Suls & Rothman, 2004). This was reflected in many psychologist participants' talk: In conceptualising sexual health as *more than just having sex*, participants often acknowledged biological aspects of sexual health but emphasised psychological, and sometimes social, aspects of this in relation to their

role as psychologists without (re-)articulating the body (i.e., without drawing links between these and the biological aspects of sexual health).

Nurses, including mental health nurses, are purportedly trained to take a specifically holistic, person-centred perspective (Australian College of Mental Health Nurses, 2015). Congruent with this, nurse participants tended to conceptualise both sexual health and mental distress in a broad way, for example explicitly positioning sexual health as being *part of the whole person*. When discussing sexuality and sexual health within the context of their everyday clinical work, however, many nurse participants tended to shift to a more biomedical and sex-focussed conceptualisation of sexual health. Mental health nurses in Higgins' (2007b) study similarly "espoused a [holistic] view of distress as a problem of living", but their practice was guided by a 'grand biomedical narrative' and they commonly drew on this to make sense of sexuality within the context of their nursing practice (p. 230). As a profession, mental health nurses tend to work in settings that are hierarchical (e.g., Fagin & Garelick, 2018), codified, and largely biomedical (e.g., Bladon, 2017). Most nurse participants in this study were working within medicalised settings that reified specific diagnostic categories of mental illness and where pharmacological treatments were almost always involved (see Barker & Buchanan-Barker, 2011). Accordingly, the settings where nurse participants works may have constrained their practice such that conceptualisations of sexual health as *all about sex* were the most pragmatic and immediately actionable, regardless of any broader conceptualisation that these participants could articulate within the interviews.

These broad patterns of inter-disciplinary difference in the way that participants made sense of sexuality and sexual health within the interviews, and reflected on these within the

context of their practice, suggests that discipline-specific modes of thinking and broader cultural norms, values, and behaviours within professions (and work setting) shape how clinicians understand these concepts.

4.3.4. Variation across the data: Clinicians as social beings.

Despite those broad inter-disciplinary patterns described above, participants' conceptualisations of sexuality and sexual health also varied within disciplines. For example, although many participants conceptualised sexual health as being all about sex, many also constructed this more broadly as more than just having sex. Moreover, not all participants constructed sexual health as either *all about sex* or *more than just having sex* in identical ways, and this was particularly prominent in relation to the latter, broader theme. This indicates that, beyond ubiquitous cultural discourses of sexuality and professional culture, broader sociocultural norms, values, and experiences may also be relevant in shaping participants' conceptualisations or sexuality and sexual health.

There is a common perception among health professionals and the general population that clinicians are somehow isolated from their experiences as social beings (West et al., 2012; also see Hafferty, 2008); but mental health clinicians are both professionals *and* social beings who are immersed in cultures and meaning-making systems beyond their profession, within a community or society. Moreover, they continue to exist and interact within these non-professional cultures even as they are socialised or enculturated into their profession. Non-professional cultural norms and values (i.e., including those socialised prior to professional training, often during primary or early socialisation) can impact how a student engages with, accepts, or rejects profession-specific modes of thinking and acting (Emmerich, 2015). This might be particularly relevant in the context of sexuality and sexual

health, where relevant professional education is lacking (described in section 1.4.1.) but clinicians are nevertheless able to make sense of and respond to these concepts, as demonstrated within this study and across existing research exploring clinicians' perceptions of sexuality within their work. Thus, although clinicians are inculcated into discipline-specific ways of thinking, clinicians may regularly draw on non-professional cultural knowledge and experiences to make sense of and respond to sexuality and sexual health as they encounter these within professional settings (i.e., within their clinical reality).

While it was clear that participants' conceptualisations of sexuality and sexual health were enmeshed with perceptions, values, and experiences from outside their professional practice, it was not possible to explore in depth how participants' understandings were shaped by their wider sociocultural perceptions and frameworks. This was because, as discussed earlier (section 4.1.1.), I did not ask participants directly about their non-professional perceptions of sexuality. Some previous research has fruitfully explored how non-professional, sociocultural perceptions and frameworks shape clinicians' perceptions of sexuality (e.g., Higgins, 2007b; Higgins et al., 2009; West et al., 2012). More research is needed that facilitates a better understanding of how clinicians' non-professional understandings and experiences in relation to sexuality impact or shape their professional practice. This is especially important given the current scarcity of relevant and appropriate formal education. If clinicians do not receive relevant education about sexual health during professional education then they must draw on knowledge gained elsewhere to make sense of questions of like 'what is sexual health' and to understand how best to respond to issues of sexuality and sexual health in their work. Developing a better understanding not only of how clinicians conceptualise sexuality and sexual health, as achieved in this study, but how or

why they conceptualise these in particular ways will support further research and interventions that aim to improve sexuality-related practice in mental health settings.

4.4 Conclusion

This analysis provided a rich description and interpretation of how mental health clinicians working in Australian contexts conceptualise sexuality and sexual health, demonstrating also that there may be no single shared conceptualisation within or across disciplines. Participants' conceptualisations of sexuality and sexual health were shaped not only by discipline-specific approaches to health (as a broad category, and to mental and sexual health specifically) but by wider sociocultural norms, values, and experiences. Participants' conceptualisations can be understood as forms of cultural knowledge that are situated in both profession-specific and broader sociocultural ways of thinking about and understanding health, sex, and sexuality. This is an important contribution to the wider literature and has implications for how research about (mental health) clinicians' perceptions of, and responses to, sexuality is both conducted and interpreted. This will be explored further in Chapter Eight.

In the three chapters that follow, I present manuscripts (both prepared for publication and published) that present analyses that focus on the ways in which clinicians perceived, encountered, and managed sexuality and sexual health in the mental health setting more specifically.

CHAPTER FIVE: Who Decides When People Can Have Sex? Australian Mental Health Clinicians' Perceptions of Sexuality and Autonomy

Statement of Authorship

Title of paper	Who decides when people can have sex? Australian mental health clinicians' perceptions of sexuality and autonomy
Publication status	Published: Accepted for publication (as presented below) 28 June 2018
Publication details	Urry, K., & Chur-Hansen, A. (2018). Who decides when people can have sex? Australian mental health clinicians' perceptions of sexuality and autonomy. *Journal of Health Psychology,* 1359105318790026.

Principal author.

Name of principal author (Candidate)	Kristi Urry		
Contribution to paper	Developed rationale for the study, research questions, and devised aims. Planned and carried out data collection and performed data analysis. Drafted, wrote, and submitted the manuscript (acting as corresponding author). Revised and responded to reviewer comments.		
Overall percentage (%)	80%		
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	23/06/2020

Co-author contributions.

By signing the Statement of Authorship, each author certifies that:

I. the candidate's stated contribution to the publication is accurate (as detailed above);
II. permission is granted for the candidate in include the publication in the thesis; and
III. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of co-author	Anna Chur-Hansen		
Contribution to paper	Input regarding study design and sampling. Supervised development of the work and provided input regarding analysis of data. Assisted in preparation of manuscript and provided editorial and structural feedback on the paper.		
Overall percentage (%)	20%		
Signature		Date	24/06/2020

Abstract

Sexuality is a central aspect of human experience but there is evidence that this is largely constrained, pathologised, or ignored in mental health settings. We conducted in-depth interviews with twenty-two psychologists, psychiatrists, and mental health nurses working across a variety of settings in four Australian cities. Sexuality was most often perceived as relevant in the mental health setting when it was simultaneously constructed as dangerous. Participants located this danger in sexual expression itself or within individuals who, because of mental illness, lacked the autonomy required to successfully engage in 'safe' sex. We discuss these findings and their implications for research and professional practice.

Keywords: Mental health; personal autonomy; professional practice; sexual health; sexuality

Introduction

Sexuality is a central aspect of human experience and people who are receiving mental health care consider sexuality, sexual expression, and intimacy to be important parts of their lives (Blalock & Wood, 2015; Deegan, 1999; Quinn & Browne, 2009). Sexual health, which refers broadly to all biological, psychological, and social factors that may impact on a person's sexuality and sexual expression, is conceptualised as a human right (WHO, 2006). Despite this, research indicates that the sexuality and sexual health needs of individuals receiving mental health care continue to be largely unmet across a range of settings.

People experiencing psychological distress or illness may have different experiences to others regarding sexuality and intimate relationships for a number of reasons pertaining to their mental (ill)health and to structural and social factors associated with mental illness (McCann, 2003; Perry & Wright, 2006; Quinn & Browne, 2009). For example, people with a

mental illness diagnosis may experience difficulties in initiating and maintaining intimate or sexual relationships due to symptomatic social withdrawal or social exclusion due to illness-stigma (Blalock & Wood, 2015; Wright, Wright, Perry, & Foote-Ardah, 2007). Changes in level of sexual desire or physical sexual dysfunction, which can occur with psychological distress or illness and commonly occurs as a side-effect of psychopharmaceutic treatment, can be distressing for individuals and difficult for their intimate partners (Quinn & Browne, 2009). There is also evidence that people experiencing psychological distress or illness may be more likely to have poorer sexual health outcomes than others, including higher rates of sexually transmitted infections and blood-borne disease, unplanned pregnancy, and sexual assault (Higgins et al., 2006b). Any of these difficulties, whether social, psychological, or biological, may negatively impact an individual's wellbeing, their experience of mental health services, and their recovery.

Despite the multiple ways in which sexuality and sexual health concerns may arise in the context of psychological distress and illness, these concerns are not regularly addressed in mental health settings (Higgins et al., 2008; Quinn & Browne, 2009; McCann, 2003). There has been only a small amount of research conducted that explores sexual health-related care in mental health settings specifically, compared with broader health care settings, and this research has been dominated by a focus on nursing practice within psychiatric inpatient settings. Nonetheless, a number of barriers for mental health clinicians to addressing sexual health needs have been identified, including embarrassment or discomfort with the topic, prioritisation of other issues, and lack of self-evaluated competence to address sexual health concerns (Quinn & Browne, 2009; Reissing & Di Giulio, 2010). That clinicians may not feel equipped to address sexuality and sexual health is unsurprising given the lack of relevant and

standardised pre-registration and continuing professional development training across mental health professions (Hendry et al., 2018; Levine & Scott, 2010; Miller & Byers, 2012).

Clinicians and researchers are social beings with their own values, attitudes, and opinions that are formed outside of, influence, and are reinforced by their practice (Kleinman, 1980), but this has often been de-emphasised in research. The ongoing lack of relevant training across mental health professions is not only a major barrier to improving sexual health-related practice in mental health settings but indicates that clinicians' knowledge and practice regarding sexuality and sexual health is likely to be influenced by a range of other sources. Accordingly, clinicians' conceptualisations of sexuality and sexual health may vary greatly within and across professions and diverge from best practice conceptualisations. It is therefore important to understand not only specific barriers to addressing particular sexual health concerns but, more broadly, how clinicians understand sexuality and sexual health in the mental health settings where they work. This was the overarching aim of the larger project of which the current paper is part. Here, we explore when and how participating mental health clinicians perceived sexuality and sexual health as relevant in the context of mental health and illness.

Method

Participant selection and recruitment.

Twenty-two interviews were conducted with a purposive sample of eight psychologists, six psychiatrists, and eight mental health nurses working in four Australian metropolitan cities. A sampling frame was generated to ensure heterogeneity within the sample for each profession across gender, age, sector (public/private), and the socioeconomic status of the areas or individuals that they serviced (higher/lower). Twelve participants

identified as women and ten as men. Two of the men openly identified as gay and one woman specifically identified herself as “heterosexual”. Most participants were of European decent and all had completed their education and training in Australia or New Zealand. Participants ranged in age from 25–75 years old and in relevant professional experience from 2 months to 40 years. Participants were working with a range of individuals and across various settings including private practice, community mental health, emergency departments, and inpatient settings (i.e., hospital or forensic settings).

Participants were recruited via advertisements posted on professional websites and circulated through professional networks, and via snowballing. In order to participate, clinicians were required to belong to their respective profession and be currently working directly with individuals in a mental health setting in an Australian metropolitan area. The project was approved by the School of Psychology Human Research Ethics Subcommittee at the authors’ university (reference:15/107). To maintain anonymity, participants were assigned pseudonyms and the interview transcripts were de-identified.

Data collection and analysis.

In-depth interviews were conducted by the first author (KU) throughout 2016 and lasted an average of 61 minutes (44–89 minutes). Eighteen interviews were conducted face-to-face and the rest were by telephone, depending on participants’ preference and location. Participants from all three professions were recruited and interviewed concomitantly. Interviews were generally directed by the participant and their experiences, using exhaustive probing to generate rich and detailed data. An interview guide served as an aide memoir, however, to always elicit participants’ understanding of sexuality, sexual health, and mental health and illness. Interviews were audio-recorded and transcribed verbatim by KU, and

participants were given the option of receiving a copy of their de-identified transcript to review and approve. KU kept an audit trail and noted preliminary codes and patterns generated during data collection. These notes were used to identify when saturation had been reached within each profession group; data collection was ceased when the authors agreed that the data were saturated within and across profession groups.

The project was guided by a social constructionist epistemology and, consistent with this perspective, we applied a form of critical thematic analysis to the data following Braun and Clarke's (2006, 2013) iterative six-step process. We were most interested in identifying latent aspects of the data in relation to the research question; that is, *how* and *why* participants understood and made meaningful their experiences in particular ways. Initial coding and analysis stayed 'close' to the data but development of the final latent themes was necessarily interpretive and theoretical. Coding and analysis was undertaken primarily by KU and the final themes were independently reviewed by the second author (ACH) against the raw data. Further detail about data collection and analysis and a reflexive statement are provided in the supplemental file (Appendix I).

Results

Participants discussed sexuality and sexual expression as "critical aspect[s] of being alive" (Ben, psychiatrist) and "part of living a normal life" (Clare, psychologist). However, sexuality was most often perceived as relevant in the mental health setting when it was simultaneously perceived as dangerous. Three themes were generated from the data regarding the construction of sexual danger: *Sex(uality) as dangerous*, *Individuals as sexually dangerous,* and *Dangerous liaisons*.

A brief note on our language throughout the remainder of the paper (see the supplemental file for a more in-depth discussion): Participants' understandings of what it means for an individual to act on or express their sexuality ranged from (hetero-) sexual intercourse to other forms of sexual activity and expression such as intimate but non-sexual touching. We use the term 'sex(uality)' to reflect the elasticity in these understandings. Similarly, there was no shared understanding of mental health and illness within or across professions, however most participants' conceptualisations of psychological distress and illness drew broadly on notions of 'dysfunctionality'. We use the term 'mental illness' in a way that reflects participants' nebulous and largely varied conceptualisations of the experiences for which individuals are engaged in mental health services (i.e., rather than referring to specific definitions or diagnostic categories for mental illness).

Sex(uality) is dangerous; but "people are going to have sex" (Jeffrey, psychologist).

Despite the varied nature of participants' conceptualisations of sexual health, most participants agreed that 'safe sex' is a central part of a healthy sexual life. Safe sex was about being responsible for the self and for others, where sex(uality) posed a physical or biological risk that needed to be managed. Sexual health was thus something to be achieved by self-regulating individuals who make the right choices to manage sexual risk by "protecting themselves and not putting themselves or others at risk" (Brett, nurse). This responsibility to protect both the self and broader society from sexual risk was reflected in an emphasis on the need for education and knowledge. It was expected that individuals should have "sexual health literacy" (Nick, psychologist) and therefore be able to make "sensible choices about things they […] choose to do about the spreading of disease" and avoiding unplanned pregnancy (Simone, psychiatrist). That sexual expression often takes place in an interpersonal

context and that many factors may contribute to the form that the expression takes was rarely emphasised.

Some participants drew singularly on this framework when talking about sex(uality) in their work, often positioning themselves as helping autonomous individuals to manage the dangers of sex(uality) through education and co-developing strategies for "managing risks [and] regulating activity" (Jeffrey, psychologist).

> So it's always about advocating safe… Safer sex. […] minimising risks wherever we can and doing it in a way that that is… Not too nannying in the sense of, people are going to have sex you know, and people are not going to use condoms all the time (Jeffrey, psychologist)

Here, Jeffrey actively constructs individuals as autonomous, sexually active, and potentially risk-taking, and positions himself as an educator with whom individuals can choose to engage. This kind of construction was more often seen in talk by participants working in private practice with individuals who had never been hospitalised (i.e., psychologists) than by participants working with individuals who were, or had been, in inpatient settings.

Individuals are sexually dangerous; "We have to protect these people and help them [to] look after themselves" (Amy, nurse).

When talking about sexuality in their work, many participants drew simultaneously on the notions that self-regulation is necessary for acceptable or healthy sex(uality) and reduced or absent in mental illness. Within this dual-framework, sex(uality) was still considered a risk but the source of sexual danger was now located primarily in the mad individual who was perceived to be lacking autonomy and therefore unable to successfully regulate their

sex(uality). This danger was present across multiple settings, including inpatient settings where individuals are "inventive" about having sex in secret [Emily, nurse] and where "sexual assaults do occur" (Eric, psychiatrist), during one-on-one sessions where there might be "sexual comments made [by individuals] which will be very uncomfortable" for the clinician (Ben, psychiatrist), and in the community:

> you have to be open to [the fact] that somebody who is disinhibited because of their mental illness and is engaging in risky behaviour... They may be putting themselves at risk of contracting an STI or things like HIV etcetera (Eric, psychiatrist)

Within the context of mental illness, sexual expression was regularly discussed as a symptom rather than a choice. This was more often seen in talk by participants working in community mental health settings and psychiatric ward settings. Participants discussed concerns regarding individuals' capacity to make good choices for themselves around sexual expression "when they're not well" as Yvonne, a nurse working in community mental health, discussed:

> [When people] become manic then they become […] very sexually disinhibited and [… they] Make poor choices around that when they're not well. About having sex with other people that they don't know and [even] when they're in committed relationships. (Yvonne, nurse)

This perceived inability of mad individuals to make good choices was not confined to periods of mania or psychosis. Participants also talked about individuals in the community, including those who are "really highly anxious or moderately to severely depressed" (Lucy, nurse), who make choices about reproduction and sexual expression that are "[not] that well informed" (Yvonne, nurse) or potentially unsafe and leading to exploitation. Participants

often constructed mad individuals as being a potential sexual danger toward others, themselves, or both. Moreover, this sexual danger was often gendered, with men perceived as posing a risk *to others* through disease transmission, sexual deviancy, and predatory behaviour, and women perceived as being *at risk* of abuse, disease, pregnancy, and distress or shame.

> [On the ward] it's usually male ['clients'] who will pursue the female clients for sex, trying to get– do the act. And of course if you've got someone who's quite vulnerable [then they're someone] who's gonna go and do it. So yeah [we have to] actually protect them. (Emily, nurse)

While men's perceived hypersexuality caused them to be a danger to others, as in Emily's extract above, women were more often constructed as simultaneously hypersexual and vulnerable. This perceived vulnerability arose specifically from a "loss of […] control of her own sexuality" (Josh, psychiatrist), situating this sexual danger within the women themselves. In contrast, men were never discussed as being vulnerable to or victims of sexual assault or exploitation because of mental illness. This gendered pattern was identified in the accounts of most participants who constructed individuals as sexually dangerous, regardless of participants' gender or profession.

Within this dual-framework of sexual danger there was little space for individuals to make decisions about their sexual expression: Any expression of sexuality could be perceived as arising from or symptomatic of mental illness, and therefore as a danger requiring control. The clinician's role was therefore to manage risk for individuals in order to protect others or to protect the individuals from themselves. In inpatient settings, sexual danger was managed primarily by prohibiting individuals from having sexual contact with each other or with their

visiting partner(s). Such encounters were considered "inappropriate and potentially harmful" (Josh, psychiatrist) because these individuals were "not necessarily able to give consent" (Eric, psychiatrist). There was also a sense that relationships and intimacy did not belong within a context of mental illness:

> They may not be detained [on the psychiatric ward], but they are unwell and because of that making some poor judgements […] it's not… the time for people to be having [or] developing new relationships […] It's just not a good time in your life to be making those choices… Yeah so, no. It's [sex is] not allowed. (Eric, psychiatrist)

Despite this, participants often knew that individuals were having sex, both in inpatient and community settings, and so other risk-management strategies were employed. It was desirable for women to be using contraception "to protect her from unwanted pregnancy" because they would be "[un]able to actually care for a child" (Josh, psychiatrist). When women who were perceived as "at risk" of pregnancy did not agree to use contraception then court-orders could be gained to enforce the use of long-term hormonal contraception (Emily, nurse). Conversely, Mia (psychiatrist) discussed the need to ensure that there is "sufficient support in place" for women who become pregnant and have children because "we don't want somebody's child to be removed". She emphasised that it is rare for her "patients" to become pregnant and have children, however, because they are "people with the more severe mental illnesses and they're often just not at that stage in their lives", reflecting Eric's idea that relationships and intimacy may not belong within the mental illness experience.

Participants focussed on protecting women from themselves more often than managing the sexual danger to others posed by men, with the exception of prohibition in inpatient settings. Some participants did talk about managing the sexual danger that men

posed to others and this was mostly in the context of "excessive" sexually deviant behaviour that was controlled using sexual suppressants (Josh, psychiatrist). For example, Amy (nurse) had worked in a community setting with a man who was considered to be at risk of acting on paedophilic desires. She insisted that the man was "not really a paedophile" but rather that his deviant desires were a symptom of his chaotic upbringing and subsequent mental illness. This perceived lack of responsibility that exonerated him for the label "paedophile" also justified the use of a sexual suppressant to forcibly control his sexual deviancy. Josh (psychiatrist) also shared experiences of "kind of castrating sexual behaviour" using sexual suppressants. He provided an exceptional case, however, by explicitly emphasising the human rights implications of "using chemicals" to affect an individual's sexual function and, more broadly, fertility. Although Josh felt that these decisions were the right ones in their clinical and social contexts, he considered them to be serious and requiring careful consideration. Very few participants discussed the human rights implications of managing perceived sexual danger, forcibly or otherwise.

> it's somebody's personal right to determine what they do with their fertility and their sexuality, and we're actually imposing in quite a significant way on that so clearly it's got implications for human rights (Josh, psychiatrist)

Dangerous liaisons; "It's really tricky" (Yvonne, nurse).

The category of madness and its associated lack of self-regulation could not always be "neatly delineate[d]" (Simone, psychiatrist). Many participants perceived a "continuum between […] what you would call normal mental health and illness" (Mia, psychiatrist) and therefore did not draw on the dangerousness of madness or sex(uality) in a static way. Rather, there was ambiguity as to when or how individuals might be considered autonomous or not

and their sex(uality) dangerous or not, as evidenced by tensions and contradictions both within and across participants' accounts. Although some participants emphasised the complicated nature of addressing sexuality in their work, judgements regarding individuals' needs were mostly presented as professional, objective, and therefore unproblematic. Yvonne's comment neatly demonstrates the active judgements made by clinicians regarding individuals' autonomy and sexual expression:

> [The ability to make choices about sex] really depends on the level of psychosis and the person. It's really tricky to have a blanket answer around that and I think it probably would be on the whole of the spectrum, yes they can make decisions [about sex] to absolutely no way, depending on the assessment of how I saw that person or assessed that person for their psychosis (Yvonne, nurse)

Sexual expressions, behaviours, and choices that were not necessarily perceived as healthy or appropriate were often constructed as potentially dangerous. Whether participants perceived individuals as engaging in 'sex for the wrong reasons' or having 'the wrong kind of sex' depended also on how they simultaneously constructed the individual's level of autonomy. Even participants who drew singularly on the *sex(uality) as dangerous* framework nevertheless described their concern for individuals who, in the context of psychological distress or illness, might have sex for the wrong reasons.

> When peoples' mental health and wellbeing is good they probably have a greater… Sense of regulation. That is, maybe not… engaging in unsafe sex as much because they <u>don't</u> <u>need</u> to. They feel okay. They feel supported, they feel loved, they feel valued (Jeffrey, psychologist)

However, these participants reinforced individuals' autonomy by giving them the freedom to make choices about their own sex(uality). This included the freedom to decide whether or not their choices might be dangerous or problematic, as Gale (psychologist) discussed in the context of an individual with a diagnosis of bipolar disorder and who had had many sexual partners. Gale acknowledged that her personal judgements or choices about sexual expression may not match the individual's but that it was the individual's judgement about her own sexual expression that should direct how or if this was addressed as a concern.

> I think it's ["promiscuity" is] a problem when… When it's serving a need. Like if they're doing it for… To fill a void then it can be problematic. But again, it's not for me to say if it is, I think it's really up to them (Gale, psychologist)

In contrast, when individuals were constructed as necessarily lacking autonomy they were not granted this same freedom to determine their sexual expression. Instead, sexual expression could be perceived as a marker of illness rather than a choice or self-expression, and so the wrong kind of sex – according to the clinician rather than the individuals themselves – could be included in the category of sexual danger. For example, for Emily, risky or dangerous sex(uality) was as much about the kind of sex or sexual activity as it was about a lack of safe sex practices. The perceived immorality of sexual expression devoid of intimacy is reflected in her concern for the distress or shame that individuals are expected to experience as consequence:

> [We need to] talk [to individuals experiencing mania] about how risky it can be because they'll just go 'round the pub and whoever's up for it, they'll be out the back [having sex] and there's no connection, there's no feelings, it's just an act. And so talking to them about [… how that] could impact on their psychological aspects [of

> health] for when they do come down and realise what they done and they're mortified (Emily, nurse)

This idea that some kinds of sexual expression are immoral and cause individuals to feel shame was used by some participants to justify protecting individuals from this danger. Emma (psychiatrist) described an experience in which two individuals who were involuntarily detained in an acute psychiatric unit were found out to have had a sexual encounter. Emma felt that the man had "preyed on this vulnerable woman who definitely didn't have capacity to consent" and was therefore very concerned that it "could be[come] quite traumatic" for the woman as she recovered from her mental illness. While Emma's concerns were based on the expectation that the woman would feel a certain way following the encounter, other participants explained that this was "not my opinion" (Yvonne, nurse) but rather what individuals had told them.

> [A client in the dialectical behaviour therapy group] brought up that a lot of her impulsive behaviour was around sexual activity, she had a lot of shame around her sexual activity […] you know, making decisions in the moment that she then wasn't happy with later (Fay, psychologist)

Ultimately though, it was always up to the clinician to decide if individuals were sufficiently autonomous to manage risk or were "at risk" from perceived sexual dangers (Emily, nurse) including disease, unplanned pregnancy, assault, exploitation, or shame. Importantly, what constituted dangerous or immoral sex(uality) was not agreed upon and could change even within a single interview. Ben's account neatly demonstrates this ambivalence as to when individuals might be ill or not, autonomous or not, and therefore dangerous or not:

> [Some patients] may not have achieved optimum mental health, and so sometimes their decision making may not be the wisest […] an obvious case is when some of our patients who do have severe mental illness [are] well enough to be in the community, but will utilise sex to augment their income. And will do that in a way that is unfortunately associated with significant risk. […] So we would be very very interested and concerned about that with some of our patients (Ben, psychiatrist)

Interestingly, Ben had previously discussed the economic challenges faced by many individuals with a mental illness diagnosis but when talking about participation in sex work he focussed almost entirely on the individual's perceived (in)capacity to make safe choices. Participation in sex work, which is perceived as a danger, became necessarily indicative of the individual's mental ill-health and reduced autonomy rather than a reflection of their economic and social circumstances. How or when an individual should be considered autonomous and self-regulating, or lacking autonomy and unable to regulate their sex(uality), was not only ill-defined across the data but within participants' own talk.

Discussion

This paper explores how Australian mental health clinicians perceive sexuality and sexual health in the context of mental health and illness. Mostly, participants considered sexuality to be relevant in the mental health setting only if it was also perceived as dangerous. Most participants drew on a framework of *sex(uality) as dangerous* and therefore requiring management by autonomous, self-regulating individuals. Many participants simultaneously drew on the notion of mental illness as a lack of autonomy or self-regulation and consequently constructed *individuals as sexually dangerous* to themselves, to others, or both. Importantly, participants moved flexibly between these constructions, especially when an

individual's perceived autonomy, and therefore the source of sexual dangerousness, was ambiguous. This flexibility allowed participants to regulate, deny, or disregard individuals' sexuality across various contexts.

That participants constructed individuals who are experiencing mental illness and are engaged in mental health services as sexually dangerous is not in itself a novel finding. In their study exploring clinicians' views of sexual health in community mental health settings, Hughes and colleagues (2018) reported that participants were generally preoccupied with risk and 'safeguarding'. That is, participating clinicians perceived sexual behaviours and expression in the context of mental illness as risky and they focussed more on risk management issues than sexual health promotion and prevention strategies. This risk-orientation identified by Hughes and colleagues is very similar to the one identified in the current study and in another Australian study with mental health nurses (Quinn & Happell, 2015c). However, these authors did not offer an interpretation as to why mental health clinicians orient toward risk at the expense of considering also sexual expression and pleasure.

There is a long history of fearing madness as a source of immorality and danger, including sexual danger, in psychiatry, law, and society more broadly (Foucault, Baudot, & Couchman, 1978; Schirmann, 2013). This fearing of madness as a danger and potential contaminant to a well-ordered society persists in the social psyche (Douglas, 1966; Levey, 2014) and was illustrated in the data; for example, in the fear of the male 'mad sexual predator' and the collective anxiety over the reproductive rights of women with serious mental illness diagnoses. Indeed, sexual danger in this study was also gendered and, similar to Dein and colleagues' (2016) findings in a forensic psychiatric setting, participants tended

to view men and women as sexually predacious and vulnerable, respectively. Outside of protecting others from men's sexual dangerousness, participants were most concerned with women's sex(uality), including the need to ensure contraception use and to restrict shameful expressions of sexuality. This also reflects Perry, Freieh, and Wright's (2018) study demonstrating that more coercive forms of 'care' are employed in relation to contraceptive interventions for women compared with men in the context of serious mental illness. This gendered understanding of sexuality reflects broader heteronormative discourses regarding gender roles and acceptable sexual expression.

Sexual dangerousness in the current study was perceived not only as a consequence of social marginality (Douglas, 1966) but constructed through a specifically neoliberal discourse of autonomy, self-regulation and morality. Within a healthcare context, neoliberal discourse promotes an expectation that people will be knowledgeable, self-managing citizens who actively make 'good choices' to manage risk and achieve or maintain health (Gaffney, 2015; Grant & Nash, 2017). This need to make good choices and manage risk is a moral obligation to society (Ellis et al., 2017). A failure to successfully self-manage sexual expression thus becomes indicative of an individual's immorality and irrationality (Levy, 2014). Participants in this study viewed individuals as sexually dangerous not just because they were mad, but because they were mad and therefore lacking the self-regulatory capacity to successfully and appropriately manage sexual risk.

What constituted immoral or dangerous sex(uality) was not agreed upon and could change depending on how participants constructed individuals as mentally ill or not and autonomous or not. Participants perceived 'healthy' people (i.e., people 'out there' in the community who do not require any form of mental health care) as being autonomous and able

to make choices about their sexual expression, while those in psychiatric inpatient settings were ill and usually (but not always) constructed as necessarily lacking autonomy. Many participants considered mental health and illness to exist on a continuum, however, and found it difficult to discern the choice-making capacity of individuals who did not exist at either extreme. The ambiguity of this liminal state of madness – not institutionalised but not 'healthy' – was reflected in the difficulty that participants had in determining or explaining when and why sex(uality) might be dangerous and how that danger should be addressed. Accordingly, participants shifted flexibly between locating sexual danger specifically within sex(uality) or within the individuals who were perceived as lacking the capacity to engage in acceptable and morally obligated 'safe' sex. In this way, participants were able to justify their perception of an individual's sex(uality) as largely irrelevant in the mental health setting, or as pathological, immoral, or otherwise dangerous and thus requiring some action or management on their part, respectively.

Oftentimes, the expressions of sex(uality) that were perceived as dangerous, symptomatic, and requiring management in the context of mental illness were simultaneously perceived being available to 'healthy' people. It was only within the context of mental illness and ambiguous autonomy that these largely stigmatised behaviours, including casual sex, infidelity, non-monogamy, and sex work, came to denote illness specifically. Moreover, once an individual had been labelled as mentally ill then these kinds of sexual behaviours and choices continued to be perceived as symptomatic and could reinvoke categorisation as mentally ill (also see Shildrick, 2007). These judgements were driven by an intention to act beneficently and keep individuals safe from harm; however, they are saturated with heteronormative and paternalistic attitudes, as well as personal and social values about what constitutes acceptable expressions of sex(uality) and when that expression should take place.

The judgements and consequent management efforts by mental health clinicians regarding sex(uality) therefore serve to reinforce and perpetuate dominant discourses and social imaginaries that construct sexuality as dangerous in the context of mental illness and mad individuals as sexually dangerous themselves (Also see Douglas, 1966; Levy, 2014; Shildrick, 2007).

Limitations.

We did not seek directly the perspectives and experiences of sexuality, intimacy, and relationships for individuals experiencing psychological distress and illness. The perspectives of individuals engaged in mental health services have been explored both in Australia (Quinn & Happell, 2015c) and elsewhere (Blalock & Wood, 2015; Deegan, 1999; Perry et al., 2018), and the experiences identified in those papers are reflected in our findings with clinicians. That we did not systematically collect information about participants' sexual orientation or identity may be considered a limitation. The interviewer avoided asking directly about personal experiences regarding sexuality and sexual health, including sexual identity, to maintain participants' comfort during interviews about an already sensitive topic. Nonetheless, discussions about participants' personal experiences were welcomed if initiated by the participant themselves. Future research might explore the relationship between clinicians' personal and professional perceptions and experiences of sexuality, sexual health, and intimacy.

Practical implications and conclusion.

The analysis presented here identifies a preoccupation with risk and danger regarding sex(uality) in the mental health setting. This reflects the long-standing focus on 'high-risk behaviours' and 'disease prevention' within sexual and mental health research more generally

(McCann, 2003; Perry & Wright, 2006; Rohleder & Flowers, 2018). Identifying and managing (sexual) risk in the context of psychological distress and illness is a pertinent and, as many participants expressed, complex issue. A prevailing focus on risk, however, comes at the expense of developing an improved understanding and practice around broader and positive aspects of sexuality and sexual health including intimacy, relationships, and identity. Moreover, orienting specifically to risk at the level of the individual overshadows the social contexts in which sexual expression occurs and tends to ignore the historical, cultural, and political context within which broader concepts of sexuality, sexual health, and mental illness have been constructed and are continually (re)negotiated.

There is a need to critically engage with and challenge dominant biomedical and neoliberal discourses that facilitate a risk-avoidance perspective and constrain efforts to take a positive, rights-based perspective to sexuality in the context of mental illness (McCann, 2003; Perry et al., 2018; Perry & Wright, 2006). Individual understandings and actions are simultaneously informed by and perpetuating of processes and discourses within healthcare systems and broader social structures (Kleinman, 1980). Thus, while not sufficient to singly effect broad institutional and policy level change, individual actions can facilitate a broadening of perspective in both practice and research away from a primary focus on sex(uality) as risk or danger. Clinicians can engage in reflection to interrogate their understandings of, professional practice around, and level of comfort with addressing sexuality and sexual health. Researchers can similarly reflect on their own values and assumptions around sexuality, sexual health, and mental illness and how these shape their research (for a discussion on taking a reflexive stance when researching stigma topics, see Wigginton & Setchell, 2016).

Clinicians and researchers strive to conceive, develop, and deliver best possible care but excluding sexuality and sexual health needs in mental health settings is at odds with this goal. Individuals engaging mental health services do not forfeit their sexual needs and rights due to mental distress or a mental illness diagnosis. We do not mean to suggest that individuals are never vulnerable or requiring of help to stay safe, or that sexuality and sexual health needs ought to be prioritised by all mental health clinicians at all times. Indeed, it is a clinician's role to care for and provide support to individuals experiencing psychological distress and illness, and this includes keeping them safe from perceived physical, emotional, and social harms. In order to do this, clinicians must make judgements regarding individuals' autonomy and their relative safety; however, this study and previous research demonstrates that such judgements and practices regarding individuals' sex(uality) are not necessarily as objective, static, or beneficent as clinicians may believe them to be.

CHAPTER SIX: "It's Just A Peripheral Issue": A Qualitative Analysis of Mental Health Clinicians' Accounts of (Not) Addressing Sexuality in Their Work

Statement of Authorship

Title of paper	"It's just a peripheral issue": A qualitative analysis of mental health clinicians' accounts of (not) addressing sexuality in their work
Publication status	Published: Accepted for publication 18 June 2019 (as presented below)
Publication details	Urry, K., Chur-Hansen, A., & Khaw, C. (2019). 'It's just a peripheral issue': A qualitative analysis of mental health clinicians' accounts of (not) addressing sexuality in their work. *International Journal of Mental Health Nursing*, *28*(6), 1278-1287. doi:10.1111/inm.12633

Principal author (candidate).

Name of principal author (Candidate)	Kristi Urry		
Contribution to paper	Developed rationale for the study, research questions, and devised aims. Planned and carried out data collection and performed data analysis. Drafted, wrote, and submitted the manuscript (acting as corresponding author). Revised and responded to reviewer comments.		
Overall percentage (%)	75%		
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	23/06/2020

Co-author contributions.

By signing the Statement of Authorship, each author certifies that:

I. the candidate's stated contribution to the publication is accurate (as detailed above);
II. permission is granted for the candidate in include the publication in the thesis; and
III. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of co-author	Anna Chur-Hansen		
Contribution to paper	Input regarding study design and sampling. Supervised development of the work and provided input regarding analysis of data. Guided preparation of manuscript and provided editorial and structural feedback on the paper.		
Overall percentage (%)	15%		
Signature		Date	24/06/2020

Name of co-author	Carole Khaw		
Contribution to paper	Input regarding study design and sampling. Supervised development of the work and provided input regarding analysis of data. Provided editorial and structural feedback on the paper.		
Overall percentage (%)	10%		
Signature		Date	24/06/2020

Abstract

Sexuality, relationships, and intimacy are integral parts of many peoples' lives, not negated by mental distress and illness. Yet typically, these needs are not addressed adequately in mental health settings. In-depth interviews were conducted with mental health clinicians with an aim of exploring their perceptions and understandings of sexuality and sexual concerns within mental health settings. Participants were 22 mental health nurses, psychologists, and psychiatrists working with people across a range of settings in four Australian cities. Sexuality or aspects of this were often not addressed in clinical practice and this was common across participants' accounts. A critical thematic analysis was conducted to explore how participants made sense of or explained this silence in relation to sexuality. Two key themes were 'Sexuality is hard to talk about' and 'Sexuality is a "peripheral issue"'. In positioning sexuality as a peripheral issue, participants drew on three key explanations (sub-themes): that sexuality rarely 'comes up', that it is not pragmatic to address sexuality, and that addressing sexuality is not part of participants' roles or skillsets. A third theme captured the contrasting perception that 'Sexuality could be better addressed' in mental health settings. This analysis indicates that, beyond anticipated embarrassment, mental health clinicians from three disciplines account for omissions of sexuality from clinical practice in similar ways. Moreover, these accounts serve to peripheralise sexuality in mental health settings. We consider these results within the context of espoused holistic and recovery-oriented principles in mental health settings.

Keywords: Mental health; Professional practice; Qualitative research; Sexual health; Sexuality

Introduction

From a holistic perspective, sexuality is understood broadly as an intrinsic part of total wellbeing that "encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction" (WHO, 2006). Within this same approach, sexual health is conceptualised as a state of biological, psychological, and social wellbeing in relation to sexuality (WHO, 2006). Sexuality and sexual concerns thus extend beyond biology, bodies, and sexual intercourse; a holistic approach means that, for example, relationships, intimacy, and self-esteem can also be understood as important dimensions of sexuality (Graugaard, 2017; McCann et al., 2019).

Sexuality, sexual expression, and intimacy continue to be important parts of life for many people experiencing mental distress or illness (Deegan, 1999; McCann et al., 2019); however, these experiences can negatively impact their ability to experience and express sexuality as they wish (Quinn & Browne, 2009). Indeed, individuals experiencing mental distress or illness report needs or concerns in relation to a wide range of psychological, social, and biological dimensions of sexuality. For instance, individuals may experience difficulties or challenges in relation to: initiating or maintaining intimate relationships within the context of symptoms of illness, mental illness stigma, and associated economic disadvantage (de Jager et al., 2017; Quinn & Browne, 2009); or in negotiating sexual safety in relation to disease transmission, pregnancy (planned and unplanned), and exploitation or violence (Higgins et al., 2006b; McCann et al., 2019). Moreover, many pharmacological treatments have common side-effects that directly and indirectly impact physical sexual function, sexuality expression, and intimacy in both men and women (see Basson & Gilks, 2018; Östman, 2014). Any of these experiences may be detrimental to an individual's mental

wellbeing and their recovery, particularly if the individual is not supported to identify, discuss, and potentially address these with a trusted mental health provider (Quinn & Browne, 2009; McCann et al., 2019).

The National practice standards for the mental health workforce (Australian Government, 2013c) espouses multi-disciplinary services that are holistic, person-centred, and recovery-oriented. This indicates the need to support individuals' sexuality, intimacy, and relationship needs as they are relevant to and valued by the individual (Australian Government, 2013c; Deegan, 1999; Quinn & Happell, 2015c; Tennille & Wright, 2013). Despite this, the sexuality-related needs of individuals experiencing mental distress and illness continue to be inadequately addressed across a range of mental health settings (Deegan, 1999; McCann et al., 2019; Quinn & Browne, 2009; Volman & Landeen, 2007). Sexuality and issues related to this thus appear to present an ongoing challenge to clinical practice in mental health settings.

Background.

The available evidence demonstrates that individuals' sexuality- and intimacy-related needs are not adequately met within mental health settings. Findings from consumer-based research indicate that individuals are often open to or would like to talk about a range of sexuality and intimacy concerns with mental health clinicians (see McCann et al., 2019). Moreover, such conversations are "often constructive, informative, and safe", yet clinicians rarely initiate these conversations within the therapeutic encounter (McCann et al., 2019, p.92). Clinician-based research reflects this, consistently demonstrating for example that mental health nurses avoid discussing or addressing sexuality across settings (Quinn et al., 2011b; Quinn & Happell, 2015c), do not routinely include aspects of sexuality in their work

(Quinn et al., 2018), and inadvertently engage a range of strategies to silence sexuality within the therapeutic encounter (Higgins et al., 2008).

Sexuality is acknowledged as a legitimate and fundamental aspect of holistic nursing care (East & Hutchinson, 2013; Higgins et al., 2006c). Owing to their "close relationship" with individuals, nurses are often perceived as being "uniquely position[ed]" to engage people regarding sexuality and sexual concerns (Higgins et al., 2006c, p.345), including within mental health settings (Quinn & Browne, 2009). Mental health services are increasingly multidisciplinary, however, and people accessing these services may encounter a range of clinicians, including nurses, over a single period of illness and their life time (Australian Government, 2013c; Australian Institute of Health and Welfare, 2018).

Limited research indicates that, like mental health nurses, psychologists and psychiatrists may also be avoidant of sexuality and sexual concerns within mental health settings. For instance, psychologists and psychiatrists appear to be under-trained regarding a holistic approach to sexuality and feel uncomfortable in raising sexuality-related issues within the therapeutic encounter (e.g., Byers, 2011; Nnaji & Friedman, 2008; Reissing & Giulio, 2010; Rele & Wylie, 2007). Reported barriers to addressing sexuality in mental health settings also appear to be consistent across nursing, psychology, and psychiatry; these include discomfort with the topic, a lack of time to address sexual concerns, and a dearth of appropriate pre-registration and continuing education (e.g., Hendry et al., 2018; Quinn et al., 2018; Reissing & Giulio, 2010).

While the available evidence clearly indicates that individuals' sexuality and sexual concerns tend to be inadequately addressed in mental health settings, the way in which mental health clinicians currently understand sexuality within the context of their work is less

understood. Moreover, few studies have examined how mental health clinicians account for avoiding, omitting, or otherwise not addressing sexuality and sexual concerns within clinical practice. The aim of the analysis presented in this article was to explore specifically the ways in which mental health clinicians currently perceive and make sense of sexuality-related silence in mental health settings.

Method

Design.

We adopted an exploratory qualitative methodology to allow an in-depth consideration of participating clinicians' perspectives on a topic that is still under-researched. The project was guided by a social constructionist approach where meaning and knowledge are understood as being contingent on social processes including language (see Burr, 2015b). Consistent with this, we applied a form of critical thematic analysis because we were interested in both the semantic content of the data and the underlying assumptions, values, and ideologies that informed participants' talk and allowed them to make sense of their experiences (Braun & Clarke, 2006).

Participants and setting(s).

Participants were eight mental health nurses, eight psychologists, and six psychiatrists (twelve women, ten men). They ranged in age from 25–75 years and their qualified professional experience ranged from 2 months to 40 years. Participants were working in four Australian cities and across a range of mental health settings including private practice (psychologists and psychiatrists only), community mental health, emergency departments (nurses and psychiatrists only), and inpatient settings (i.e., hospital or semi-forensic settings).

Three participants were working specifically in relation to some aspect of sexuality or sexual health. Participants were recruited by advertisements circulated through professional websites and networks, and via snowballing. Participation was voluntary and participants were not remunerated for their time.

Data collection.

In-depth qualitative interviews (18 face-to-face and 4 via telephone) were conducted by KU in 2016 and lasted an average of 61 minutes (44–89 minutes). Face-to-face interviews were conducted at the authors' university campus or at the participant's workplace, as they preferred. Interviews were audio-recorded and transcribed orthographically by KU. Sixteen participants (Seven nurses, five psychologists, and four psychiatrists) chose to receive a copy of their de-identified transcript and three participants provided further clarifying remarks which were included (with consent) in the dataset.

Interviews were primarily participant-led, using exhaustive probing to generate rich data. An interview guide was used as an aide memoir to ensure that all major topics of interest were discussed, including participants' understandings of sexuality, sexual health, and mental illness, and their perceptions of addressing sexuality and sexual concerns in their practice. An audit trail was maintained throughout the project to note ideas, interesting points, and any problems. Interviewing stopped when the authors agreed that there were no new perspectives being generated, both within and across the three profession groups; this pragmatic decision was arrived at through inspection of the audit trail and discussion.

Data Analysis.

The first author conducted the critical thematic analysis, guided by Braun and Clarke's (2006) iterative six step process: familiarisation through transcription and repeated

reading of the transcripts; coding, which was managed using N*Vivo 12 (QSR International, 2018); generating themes; reviewing and defining themes; and 'writing up', during which time the analysis is further refined. Initial coding was inductive and data-driven, and this became more interpretative as themes were generated, reviewed, and defined. All authors discussed the analysis at all stages but KU made the final analytical decisions because she was most familiar with the data.

Ethical issues.

The project was approved by the School of Psychology Human Research Ethics Subcommittee at the authors' university (reference:15/107). Prior to commencing each interview, the interviewer (KU) explained the project to participants and gained both verbal and written informed consent. Participants who were interviewed by telephone returned a signed consent form before the interview and then confirmed their consent verbally via the phone call. Participants were assigned a pseudonym and transcripts were de-identified.

Results

Participants generally perceived sexuality as an important part of life that is intrinsically connected with mental wellbeing. Nevertheless, sexuality and sexual health (or aspects of these) were regularly omitted from everyday clinical practice and this was common across participants' accounts. Two key themes are presented that capture how participants accounted for or made sense of these omissions: 'Sexuality is hard to talk about' and 'Sexuality is a "peripheral issue"'. The first of these themes reflects closely the results of other studies that have explored (mental health) clinicians' perceptions of sexuality (e.g., Higgins et al., 2008; Quinn et al., 2011b; also see Quinn & Browne, 2009) and we therefore present it only briefly. The second theme, which includes three sub-themes, is the major

contribution of this analysis and is presented in detail. Participants also challenged sexuality-related silence within the mental health setting, and a third theme captures this: ‘Sexuality needs to be better addressed’.

We use the terms ‘sexuality’ and ‘sexual concerns’ to reflect the varied and nebulous ways in which participants conceptualised and talked about sexual expression, sexuality, and sexual health within and across interviews. These terms encompass (but are not restricted to) biological aspects of sexual health. Extracts are provided to illustrate the analysis: words added to improve readability are in square parentheses, sections removed for concision are indicated by […], and words stressed by the speaker are underlined.

Sexuality is hard to talk about.

All participants perceived sexuality as a sensitive, delicate, awkward, or even potentially distressing topic that is difficult to talk about, both in general and within the therapeutic encounter. Anticipated embarrassment for both individuals and clinicians was understood to be a major barrier to communicating about sexuality across all mental health settings and professions. Clinicians were seen as primarily responsible for initiating these conversations because individuals were perceived as being too embarrassed to do so.

> and people being embarrassed and not willing to or not necessarily identifying that so you need to ask [about treatment-induced sexual dysfunction…] I think people wouldn’t necessarily bring it up. Or they’d be reluctant until they know you better or whatever. (Eric, psychiatrist)

In particular, participants felt uncomfortable to discuss sexuality with individuals who differed from them in gender, or who were perceived as being especially young or old, devoutly religious, or belonging to a minority cultural group. These differences or

characteristics were usually seen as indicating that the individual would find discussions about sexuality as particularly uncomfortable or inappropriate, and this heightened clinicians' own discomfort.

Participants were aware that discomfort with the topic of sexuality, and its association with "shame, embarrassment, [and] stigma" (Sandy, nurse), was entangled with broader sociocultural understandings of sexuality as taboo. This was generally presupposed and unchallenged; being comfortable to talk about sex and sexuality was an exception to the rule rather than the norm. Indeed, participants who felt comfortable in discussing sexuality within the therapeutic encounter often perceived themselves as different to the majority of their colleagues.

> A lot of nurses don't [talk about sexuality, they say] "can't talk about that oh sexual [issues] no we don't do that sort of thing". It's part of life. I don't care if they talk to me about it. (Emily, nurse)

A good therapeutic relationship, in which there was a sufficient level of trust, safety, and openness, was commonly seen as a requirement for conversations about difficult topics including sexuality. Discussing sexuality was also perceived as having the potential to damage that relationship, however, and this concern was managed differently across the dataset (but not patterned across specific professions or settings). Some participants emphasised the need to raise difficult topics early in order to establish good rapport. Others stressed the importance of avoiding those topics until later, or even completely, in order to avoid "damaging" the therapeutic relationship (Ben, psychiatrist). Many participants, particularly those who perceived sexuality as a potential threat to the therapeutic relationship, felt that if an individual had a sexual concern then they would 'bring it up' themselves,

unprompted. This strategy might avoid (clinician) discomfort within the therapeutic encounter but it was also in direct contradiction to the equally common perception, discussed previously, that it is the clinician's responsibility to raise conversations about sexuality.

> I don't really see [sexual concerns] as something that I would necessarily raise because I'm not setting the agenda. They are. They come to me with particular presenting complaints and I'm responsive to that […] (Josh, psychiatrist)

Though not commonly acknowledged, participants across all three professions discussed the need for clinicians to be self-reflexive about their own beliefs, values, and experiences in relation to sexuality, in order to provide best care.

> I think if people aren't okay with their own sexuality their own… comfortableness with themselves their own self-esteem all of that stuff has an impact on whether you're able to talk to clients about [sexuality and sexual health…] (Yvonne, nurse)

Sexuality is a "peripheral issue" (Dean, nurse).

Participants commonly discussed their own and colleagues' omissions of sexuality or aspects of this in clinical practice. In addition to explaining how difficult it can be to talk about sexuality in the therapeutic encounter, participants accounted for these omissions by positioning sexuality as a peripheral issue that largely does not belong in mental health settings. Three key explanations were drawn on: that sexuality rarely 'comes up' in participants' everyday work, that it is not pragmatic to address sexuality, and that addressing sexuality is not part of participants' roles or skillsets.

It doesn't come up in my role.

There was a common perception across all disciplines and settings that it is "unusual" for sexual concerns to 'come up' in participants' work (Scott, psychologist), and that this was why participants rarely addressed sexuality-related issues. There was an underlying assumption that individuals are generally not experiencing sexual concerns or that any sexual concerns that they do have are not relevant to or impacted by their experience of distress (i.e., as they did not raise any concerns).

> I do talk [about sexuality issues] sometimes and you know it's not very often because there is such a complicated web of stuff going on for these people. It's not terribly often but if they do want to kind of talk about how that goes for them [then we do]. (Gale, psychologist)

Sometimes, the perception that sexuality does not often 'come up' was related to the way in which participants conceptualised sexual concerns more generally. Some participants understood sexuality or sexual concerns as a narrow set of issues that were primarily biological (i.e., related to sexual function, intercourse, and disease or risk) or related to violence. Sexuality therefore came up irregularly because these issues (particularly in relation to disease) were not raised or were not relevant within the therapeutic encounter. Conversely, a few participants felt that sexual concerns did 'come up' but specifically in relation to these limited issues. There was little discussion about broader aspects of sexuality including, for example, intimacy, pleasure, and relationships.

> Well obviously our mental health patients are the most vulnerable in terms of sexual health because a lot of our clients will either have sex for money or drugs and not have protected sex and they'll have sex with a lot of different men. A lot of our

consumers are so vulnerable they get raped and you know obviously are too scared to tell anyone because it re-traumatises them. (Jake, nurse)

Often, the perception that sexuality does not 'come up' was built around assumptions or stereotypes that rendered sexuality less important for some groups of people. A lack of interest in expressing sexuality or having intimate relationships was typically seen as symptomatic of some "severe mental illness[es]" such as schizophrenia (Ben, psychiatrist) and so sexuality was often understood as less relevant for people with these diagnoses. Similarly, older people were often conceptualised as asexual and women's sexuality was regularly erased in relation to treatment-induced sexual dysfunction (i.e., participants predominantly discussed this issue in relation to men only, despite evidence that women also experience iatrogenic sexual dysfunction: see Basson & Gilks, 2018).

Yvonne: […] and I'm predominantly focussing on men because a lot of the antidepressants and medications that they take do effect their ability to get and maintain an erection and all that sort of stuff, and so I have talked to them about that. […]

Interviewer: Do medications affect women as well?

Yvonne: I'm sure they do. But it's not something that I have ever talked to them about. Have I? Gosh… I don't think it is. I don't think any women has ever talked to me about how it is that affects their sexual functioning… Nope. (Nurse)

Conversely, a few participants talked about how "a whole range of different aspects of sexuality and sexual expression and sexual health" did 'come up' regularly in their roles (Lucy, nurse). These data challenge the legitimacy of the opposite and more common perception that it is rare to encounter relevant sexual concerns in mental health settings.

> it changes a little bit in terms of the hat that I've got on for that day in terms of what aspects of sexual health might come up but I think I'd be hard-pressed to see any job that I've worked in where it doesn't come up at all. (Emma, psychiatrist)

I'm being pragmatic.

Participants perceived sexuality as lacking priority within the therapeutic encounter compared with "more pressing" issues (Scott, psychologist) and tended to "prioritise other stuff" over sexual concerns (Lisa, psychologist). Prioritised concerns usually related to symptoms or perceived risk associated with mental distress or illness experiences; but these could also include other concerns such as drug and alcohol abuse and (particularly in the context of community mental health) functional living skills including hygiene and money management.

> when someone comes in here often they're trying to hurt themselves or others or putting themselves or others at risk in some way and that tends to trump you know 'how's your relationship going how's your sex life going are you having any problems with that', that seems to come later um and in a public system […] you may only be seeing people in those times of crisis so you might not be building the relationship up to remember to ask to think to ask to have time to ask about all of those other factors […] (Emma, psychiatrist)

Like Emma, other participants also described situations or encounters where it may not be "contextually appropriate" (Josh, psychiatrist) to raise or prioritise issues related to sexuality, such as during specific cognitive or crisis assessments. Often though, the perceived need for pragmatism expanded to a broader concern that raising sexuality or sexual concerns

was mostly not relevant within the therapeutic encounter or not useful in achieving the therapeutic goals, as determined by either the clinician or the individual.

> at the end of the day it's about assessing what gain do you get from enquiring uh taking that line of enquiry [regarding sexual concerns]. You know I really have to decide before I go down that path, is this really going to be helpful to the patient or to me to know about that part of it. That probably is the bigger juggling act. (Ben, psychiatrist)

This broader notion that raising sexual concerns may not be very useful, or pragmatic, served to orient away from the possibility that sexuality could be an important part of individuals' lives (McCann et al., 2019), and that aspects of sexuality may be impacted by or impacting on people's experience of distress (Quinn & Browne, 2009). Typically, sexuality was perceived as being a low priority for many people who are experiencing mental distress and illness. Addressing symptoms of mental illness directly was seen as being of greatest importance for both the individual and the clinician. Moreover, many participants felt that recovery from clinical symptoms of distress would necessitate recovery of 'everything else'. In this way, the potential importance of sexuality for the individual was acknowledged, but it remained irrelevant within the therapeutic encounter:

> the whole idea of trying to help them through [their experience] is to get out the other side [… so if] they're depressed what you'd hope is that they're not depressed anymore and that all the aspects of their life that should be up and running which would include relationships and sexuality […] (Mia, psychiatrist)

Several participants challenged this prevalent understanding that sexuality mostly is not a priority for people experiencing mental distress or illness, and therefore not a priority

within the therapeutic encounter. For instance, Emma (psychiatrist) acknowledged the potential for sexuality and sexual function to be main priorities for individuals despite major symptoms of distress, or for these to become a priority after those symptoms have been "stabilised".

> I have had patients come in and [treatment-induced sexual dysfunction is] their primary complaint and they come in and they're not worried about the psychosis they're just worried about the fact that they aren't sexually functioning in the way that they would like. (Emma, psychiatrist)

It's not my job.

Participants who were not working specifically in relation to sexuality often positioned sexuality, or specific aspects of this, as being someone else's job and not part of their own professional role. Accordingly, if sexual concerns did arise, then individuals were often referred away to other clinicians. Sometimes these referrals were to other clinicians or disciplines within mental health services, such as (specialised) psychologists in relation to specific sexual interventions or intimacy issues within couples. Nurse participants usually directed individuals to their prescribing psychiatrist regarding treatment-induced sexual dysfunction; however many psychiatrist participants perceived these dysfunctions as largely unavoidable (i.e., something to acknowledge but not always something that can or should be addressed directly) and often referred individuals who were experiencing sexual dysfunction (specifically erectile difficulties) to a general practitioner in order to access Viagra.

Mostly, participants saw sexual concerns as best referred away from mental health settings entirely, often to a GP or a specialised sexual health service. Participants often assumed that medical providers (other than psychiatrists) would identify and address sexual

concerns as part of their routine practice. In this way, sexuality was situated as belonging outside of the mental health realm more generally and therefore not a part of participants' roles.

> **Interviewer**: So whose role would it normally be to provide sexual health care?
>
> **Fay**: No one's. No um I guess we would normally say the GP's [general practitioner's]. (Fay, psychologist; working in multidisciplinary community mental health setting)

Some participants did perceive that it was part of their role to support individuals' sexual needs, even indirectly.

> We're not sexual experts in itself but we coordinate the care and make sure that we've referred them [to an appropriate service] and take them there if they're a bit resistant. […] we're partly responsible for making sure that we get those links going very closely. (Amy, nurse)

Many participants perceived that addressing sexuality requires special skills or expertise that they did not have. Sometimes this was couched within a broader aim to provide best care by referring sexual concerns away when "somebody [else] can do this work better than me" (James, psychologist). More commonly though, participants asserted that "I'm *not* an expert" (Josh, psychiatrist) with little reflection on what their perceived lack of expertise might mean for individuals' experience of care.

> We're probably not skilled or trained or educated enough to pass that [kind of information] onto the young people. It's kind of just like a peripheral issue for us […] We note [sexuality-related concerns] but we don't directly deal with it. (Dean, nurse)

A few participants directly challenged the common perception that sexuality is a specialist area that is separate from mental health. They perceived the bracketing of sexuality away from "a model of life and health and wellbeing" as detrimental to holistic care (Fay, psychologist).

> I think you should have a basic working knowledge. And it's an everyday thing. So I don't see the reason it should be a specialist area. (Emily, nurse)

Sexuality needs to be better addressed.

Participants often commented on or talked about the idea that sexuality or specific aspects of this could be better addressed by themselves or their colleagues, or within mental health settings more generally. Some participants arrived at the interview with a specific understanding that sexuality needs to be better addressed in mental health settings in some way(s).

> I think [sexuality and especially sexual function] needs to be encompassed into the recovery process. I think it's an important part of our clients' lives that needs to be explored further […] (Brett, nurse)

More often, participants arrived at this idea through reflection during the interview, where they came to identify a gap between their approach to care and their own or others' practice (i.e., holistic care, which they came to conceptualise as including sexuality, and the omission of sexuality from routine practice). The idea that sexuality is "not addressed as much as it should be" (Sandy, nurse) was often ambiguously presented; participants alluded to an ideal way of delivering care that was not currently being realised but were often unable to articulate what it would mean to achieve that 'ideal'.

> I think it's probably something that we don't ask about that much. Probably as a team. Or I've worked with a couple of different teams so it's not just this team but as a public mental health system […] I think we don't talk about sexuality as much as we should when we're assessing and treating. (Fay, psychologist)

Discussion

Despite acknowledging the potential importance of sexuality and sexual wellbeing for mental health, participants in this study regularly omitted sexuality or aspects of this in their practice. All participants perceived sexuality as an embarrassing or taboo topic and, consistent with previous research across health settings, this was perceived as a barrier to communication about sexuality for both clinicians and individuals (Katz, 2005a; Quinn & Happell, 2012; Reissing & Giulio, 2010). In addition to anticipated embarrassment, participants accounted for omissions of sexuality by locating it outside of their immediate clinical responsibilities and competencies, and on the periphery or outside of mental health settings more broadly. This is contrary to a holistic, recovery-oriented approach to care where sexuality and intimacy may be an important dimension of people's overall wellbeing that impacts their recovery (Quinn & Browne, 2009; Tennille & Wright 2013).

Other studies have similarly reported that mental health clinicians omit sexuality in their practice, for example by simply not raising the topic and by referring sexual concerns to other clinicians due to self-perceived lack of expertise (Higgins et al., 2008; Miller & Byers, 2012; Quinn et al., 2011b). Of particular interest within the current study, participants consistently situated sexuality, sexual concerns, and intimacy as lacking importance within the clinical perspective. 'Pragmatic' omission of sexuality has also been reported in other studies with mental health nurses but these have tended to focus on structural constraints and

participants' underlying discomfort with and desire to avoid the topic (Higgins et al., 2008; Quinn et al., 2011b), rather than participants' understanding of how or why sexuality might be (un)important within the therapeutic encounter. In the current study, participants' omissions of sexuality were likely also informed by broader structural constraints and by discomfort; however, participants were not only constrained by structurally and socially perpetuated silence, but directly reproduced this in their accounts by situating sexuality as peripheral to or not belonging in mental health settings.

While sexuality is not necessarily a priority for all individuals at all times, there was little space in many participants' talk for the potential that sexuality might be(come) important to individuals and therefore relevant within the therapeutic encounter. This is contrary to evidence that individuals engaging mental health services would like more support in relation to sexuality and intimacy (McCann et al., 2019). The de-prioritisation of sexuality in favour of the clinicians' professional agenda (e.g., to reduce clinical symptoms of 'illness') may therefore reflect a broader failure to engage recovery-oriented care, which requires the clinician to engage in dialogue with the person to understand how they are making sense of their experience and what is important to them (Guilfoyle, 2003; Higgins et al., 2008).

Some participants recognised the need for sexuality to be better addressed and this directly challenged the common idea, often expressed within the same interview, that sexuality does not belong in mental health settings. Mental health nurse participants in other studies have also identified (often through reflection within the interview) the need to better address sexuality but tend to locate responsibility for this outside of their immediate therapeutic duties (Quinn & Happell, 2015c), in "other mental health clinicians" (Quinn et

al., 2011b, p.25), or in broader structural configurations (Higgins et al., 2008). Similarly in this study, participants' suggestions that sexuality should be better addressed tended to be vague and focussed on colleagues' practice, the (mental) health system, or an ambiguous "we", rather than their own practice. These discussions may therefore have functioned rhetorically within the interview to deflect from participants' own complicity in reproducing silence in relation to sexuality by situating this within a wider issue for which they are not individually responsible.

Although we focussed on clinicians' perceptions and (reported) practice choices in this analysis, it is important to acknowledge that clinicians do not practice in a vacuum. While individual clinicians' perceptions and practice choices may contribute to reproducing sexuality-related silence in mental health settings, as this analysis suggests, many of these choices are formed and reinforced by the broader institutional structures within which clinicians learn and work (see Hendry et al., 2018; Higgins et al., 2008, 2009). Accordingly, clinicians' everyday practice should not be the sole focus of research and interventions that aim to redress this issue. It is important to understand how clinicians currently perceive sexuality and to improve their knowledge, comfort, and competence in incorporating sexuality and intimacy into their practice where appropriate (e.g., McCann et al., 2019; Miller & Byers, 2012; Levine & Scott, 2010; Quinn & Happell, 2012). Procedural and structural constraints on addressing sexuality also need to be better understood, however, and efforts made to embed sexuality within clinical practice at the service and system levels.

Finally, many participants relied on common but inaccurate stereotypes to make sense of their own and others' discomfort in discussing sexuality, including assumptions based on age and gender (e.g., Quinn et al., 2011b) and religiosity (Attalah et al., 2016). This indicates

the need to ensure that sexuality-related education at all levels challenges common stereotypes and sufficiently explores sexuality across the lifespan and outside of traditional gendered assumptions. Cultural sensitivity training may also be useful (Attalah et al., 2016), but more research that examines sexuality within multi- and cross-cultural care contexts is required. The view that sexuality and sexual expression is neither important nor relevant in the lives of people experiencing mental distress and illness was also common. This may be rooted in broader social anxieties regarding sexual expression in the context of mental illness (Quinn & Browne, 2009) that also shaped participating clinicians' perceptions of sexuality in their work (Urry & Chur-Hansen, 2018[47]).

Limitations.

The clinicians who volunteered to participate in this study felt comfortable enough to talk about sexuality with a researcher and reflect on this specifically in relation to their work. Accordingly, their perceptions might differ from those who did not participate. Participants were also all based in Australian cities: rural and remote locations are differently resourced and clinicians working in those contexts might approach sexuality and sexual concerns in different ways. Despite both of these potential limitations, our results do reflect reports of similar Australian-based research from other locations (e.g., Quinn et al., 2011b). Further research could include purposive sampling of clinicians working in rural and remote areas. Moreover, triangulation with stakeholders, including clinical supervisors and people who are accessing mental health services, could further contribute to knowledge regarding the

[47] This refers to the publication presented in Chapter Five.

perceptions and approaches of health professionals, including those who are uncomfortable with sexuality and sexual health.

Conclusion.

This study demonstrates that mental health nurses, psychologists, and psychiatrists account for omissions of sexuality from clinical practice in similar ways. Moreover, it suggests that mental health clinicians are complicit in reproducing silence in relation to sexuality by deprioritising it and locating it outside of their professional responsibilities and mental health settings more generally. Omissions of sexuality from clinical practice and clinicians' justification for this is not ill-intentioned, nor something that clinicians are necessarily aware of (Higgins et al., 2008). Nonetheless, the results of this and other studies challenge the idea that clinical practice in mental health settings is holistic and recovery-oriented (e.g., Higgins et al., 2008; McCann et al., 2019).

Relevance for clinical practice.

Most participants in the current study had not spent much time prior to the interview thinking about or reflecting on their views about sexuality or their understanding of how sexuality might be relevant to their roles. While clinicians cannot be expected to shoulder the responsibility for 'solving' the problem of sexuality-related care in mental health settings, there are actions that individual clinicians can take to improve their own practice. As indicated in the analysis and identified in other studies, clinicians can engage in critical reflection on their personal understandings and professional practice in relation to sexuality (McCann et al., 2019; Quinn et al., 2011b; also see Hendry et al., 2018), either alone or with colleagues. In doing so, clinicians might seek out educational opportunities or engage in self-directed research to deepen their understanding of the ways in which sexuality can be

important in the lives of people experiencing mental distress and illness across a range of contexts and settings (e.g., Byers, 2011; Deegan, 2019; McCann et al., 2019; Quinn & Browne, 2009) and the ways in which clinicians can raise and respond to sexuality-related concerns (e.g., Attalah et al., 2016; Basson & Gilks, 2018; Evans, 2011; Love & Farber, 2017). Increased awareness of the potential importance of sexuality within the context of mental distress or illness may itself increase confidence in raising and addressing sexuality within the therapeutic encounter (Quinn & Happell, 2012; Miller & Byers, 2012).

CHAPTER SEVEN: "It's Not Really A Part of Standard Practice": Institutional Silencing of Sexuality Within Australian Mental Health Settings

Statement of Authorship

Title of paper	"It's not really a part of standard practice": Institutional silencing of sexuality within Australian mental health settings
Publication status	Manuscript prepared for submission to *Social Science & Medicine*
Publication details	Urry, K., Chur-Hansen, A., & Khaw, C. (--). "It's not really a part of standard practice": Institutional silencing of sexuality within Australian mental health settings.

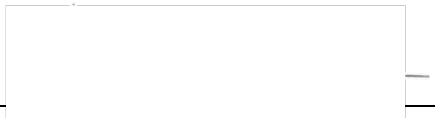
Principal author.

Name of principal author (Candidate)	Kristi Urry		
Contribution to paper	Developed rationale for the study, research questions, and devised aims. Planned and carried out data collection and performed data analysis. Drafted and wrote the manuscript (will be responsible for submitting the manuscript and acting as corresponding author).		
Overall percentage (%)	80%		
Certification	This paper reports on original research I conducted during the period of my Higher Degree by Research candidature and is not subject to any obligations or contractual agreements with a third party that would constrain its inclusion in this thesis. I am the primary author of this paper.		
Signature		Date	23/06/2020

Co-author contributions.

By signing the Statement of Authorship, each author certifies that:

I. the candidate's stated contribution to the publication is accurate (as detailed above);
II. permission is granted for the candidate in include the publication in the thesis; and
III. the sum of all co-author contributions is equal to 100% less the candidate's stated contribution.

Name of co-author	Anna Chur-Hansen		
Contribution to paper	Input regarding study design and sampling. Supervised development of the work and provided input regarding analysis of data. Provided guidance on preparation of manuscript and editorial and structural feedback on the paper.		
Overall percentage (%)	10%		
Signature		Date	24/06/2020

Name of co-author	Carole Khaw		
Contribution to paper	Input regarding study design, sampling, and analysis of data. Provided editorial and structural feedback on the paper.		
Overall percentage (%)	10%		
Signature		Date	24/06/2020

Abstract

Research that seeks to understand and improve sexuality-related practice in mental health settings tends to focus on clinicians' relevant knowledge, comfort, and competence; but clinicians' perceptions and practice choices occur within, and are not separate from, a broader institutional context. It is therefore important to consider this context in research. This article is part of a larger study that explored the perceptions of sexuality and sexual health in mental health settings for mental health professionals in Australia via in-depth interviews. Participants commonly discussed or constructed sexuality-related silence within their work settings. The critical thematic analysis presented here was conducted to examine specifically when and how participants implicated their workplaces, professions, and broader institution(s) when talking about and making sense of sexuality-related silence in their work. Broader silences that shaped and reinforced participants' perceptions and practice choices were situated in professional education, workplace cultures, and the tools, procedures, and policies that directed clinical practice. We argue that sexuality-related silence in mental health settings is not located in clinicians' deficits; but in the institutional contexts in which they learn and work. We discuss the utility in orienting toward the ways in which sexuality is constructed and silenced at the institutional level through discursive, structural, and material configurations.

Keywords: Australia; Mental health services; Professional education; Qualitative; Sexual health; Sexuality; Socialisation; Staff perception

Introduction

A recovery-oriented approach now underpins mental health services in many countries including Australia (Australian Government, 2013c). Within this approach, the

sexuality and sexual health (SSH) needs that are relevant to and valued by the individual should be incorporated into the person-centred care provided to them (Deegan, 1999; Quinn & Browne, 2009; Quinn & Happell, 2015a; Tennille & Wright, 2013). SSH needs can be wide-ranging, spanning biological, psychological, social, and cultural domains (Graugaard, 2017; WHO, 2006) that might be negatively impacted by, or impact on, individuals' experience of mental distress or mental illness diagnosis and treatment (Deegan, 1999; McCann et al., 2019). Despite this, research demonstrates that individuals' SSH needs continue to be largely avoided or ignored within mental health settings (e.g., McCann et al., 2019; Quinn et al., 2011b).

Previous research on SSH has tended to focus on mental health clinicians' knowledge, comfort, and competence (e.g., Miller & Byers, 2012; Quinn & Happell, 2012; Reissing & Di Guilio, 2010). While that research has made important contributions, it often fails to contextualise clinicians' knowledge, comfort, or competence within the wider environment: Clinicians' practice, including in relation to sexuality, is shaped by the institutional contexts in which they learn and work. Medical and other health-related institutions, including psychiatry and psychology, have historically pathologised and silenced sexuality within the context of mental distress and illness, and there is little evidence that there has been a radical shift in the way that these institutions approach and understand sexuality (e.g., Perry et al., 2018). It is therefore unproductive to continually, and only, ask why mental health *clinicians* have not achieved a radical shift in the way that they approach sexuality and are able to raise and respond to the sexuality and intimacy needs of individuals accessing mental health services. This article focuses on this broader institutional context in order to contribute to a more nuanced understanding of why SSH continue to be under-addressed within mental health settings despite ongoing research and efforts to improve this.

Sexuality and the institution.

As systems of knowledge, institutions are shaped by sociocultural norms and discourses[48] and, through their authority to make truth claims, they contribute to producing and reinforcing these norms over time (Foucault, 1980; Lupton, 1997; McFarland, 2015). Dominant discourses generally represent or reproduce a particular status quo and have strong institutional bases (Weedon, 1997). Health-related institutions including medicine, psychiatry, and mental health professions more broadly, are implicated in defining normalcy and deviancy in relation to bodies, psyches, and ways of being in or experiencing the world (Lupton, 1997). Specifically, the disciplines of medicine, psychiatry, and psychology (as well as sexology and public health) have directly contributed to defining what is perceived as normative, healthy, and acceptable sexuality, sexual expression, and relationships (e.g., Barker et al., 2018; Foucault, 1980; Sullivan, 2003; Weeks, 2010). These normative understandings – or, dominant discourses – are generally heteronormative and ableist (Barker et al., 2018; Rubin, 1984; Shildrick, 2009), and increasingly medicalised (e.g., evidenced by the large focus on sexual *dysfunctions* and medical treatments for these: Tiefer, 2006). A biomedical and neoliberal approach to (sexual) 'health' also means that sexuality tends to be understood narrowly as 'sex' (i.e., sexual intercourse) and individuals are required to take precautions to be biologically safe regarding reproduction and the transmission of infection (see Epstein & Mamo, 2017).

Within the context of mental distress and illness specifically, individuals have been historically excluded from broader understandings of normative sexual expression or sexual

[48] Discourses are understood here as the meanings organised around phenomena, which could be a physical or social object, an event, a person, an identity category and so on; these delimit what is sayable and knowable about those phenomena within specific historical and sociocultural contexts (e.g., see Burr, 2015a; Lupton, 2012; Weedon, 1997).

rights (Perry et al., 2018; Quinn & Browne, 2009; Weeks, 2010). The disciplines of psychiatry and psychology have directly contributed to producing and reinforcing enduring sociocultural understandings that people experiencing mental distress, and particularly those with a mental illness diagnosis, are necessarily disinterested in sexual expression or sexually dangerous via sexual predation or socially proscribed reproduction (e.g., based on the idea that madness is hereditary and people with mental illness diagnoses should not have children: see Quinn & Browne, 2009). This functions to achieve the maintenance of a culturally and historically specific status quo regarding the bounds of normal, healthy, and appropriate sexualities and their expression (Foucault, 1980; Rubin, 1984). Risk averse, prohibitive, and even punitive attitudes towards sexuality within the context of mental distress and disability more broadly continue, both within mental health settings (Brown et al., 2014; Perry et al., 2018; White et al., 2019) and in wider social contexts (Shildrick, 2009). Sexuality can therefore be understood as a site of ongoing social control over people experiencing mental distress and illness that functions to both to 'protect' wider society and maintain normative sex standards.

The institution and its professionals.

Despite increasing efforts to better acknowledge and address individuals' sexuality and intimacy needs within recovery-oriented mental health care, these needs continue to be inadequately addressed across a range of mental health settings (e.g., McCann et al., 2019; Quinn et al., 2011b; Zatloff et al., 2020). A dearth of appropriate sexuality-related professional education is commonly observed across mental health disciplines and reported to contribute to clinicians' pervasive discomfort with and avoidance of sexuality and intimacy concerns within their everyday practice (Miller & Byers, 2012; Quinn & Happell, 2012;

White et al., 2019). This is often interpreted as producing a skill deficit in clinicians, which in turn drives a continued and common research focus on clinicians' competence and confidence in raising and addressing sexuality within the therapeutic encounter. While important, such an approach fails to acknowledge the impact of the broader environment and institution in shaping and constraining clinicians' practice in relation to SSH. Recent studies have suggested that there is a need for improved organisational supports, such as clear guidelines or relevant proformas, to support clinicians to address sexuality and intimacy needs (Hughes et al., 2018; White et al., 2019; Zatloff et al., 2020).

Consistent reports of a dearth of relevant training and organisational level supports is also indicative of a broader institutional silencing of sexuality within mental health settings. This has been identified and explored elsewhere, to varying degrees. In a focus group study in the United Kingdom, nurse and psychiatrist participants perceived that discussing sexual health was not a legitimated part of routine practice at the organisation level (Hughes et al., 2018). A grounded theory study in Ireland explored in detail how mental health nurses' practice in relation to sexuality is shaped, both directly and indirectly, by wider sociocultural and professional discourses that act to veil or silence sexuality (Higgins et al., 2008, 2009). The authors demonstrated that nurses working in a community mental health setting in Ireland had come to understand sexuality "as sex", socially taboo, and risky prior to entering their professional education, through socialisation processes in their home and secondary schooling (Higgins et al., 2009, p. 359). These biomedical and reductionist discourses constructed sexuality as primarily reproductive, de-eroticised, and pathologised (emphasising disease or deviance), and they were unchallenged or reinforced through the nurses' professional education. Unsupported by their professional education, the nurses tended to look to more senior colleagues for cues on how to approach sexuality within the therapeutic

encounter; but, having been similarly socialised and educated, senior nurses modelled a range of veiling strategies that mental health nurses came to learn and reproduce through their own practice (Higgins et al., 2009). Overall, the limited available evidence indicates that excluding SSH from the mental health setting "is an implicit institutional position" (Hendry et al., 2018, p. 7).

The notion that health clinicians are socialised into their discipline's professional culture is well established (Bloor & Dawson, 1994; Clouder, 2003; Emmerich, 2015; Lupton, 2012), though this has not commonly been considered within research exploring mental health clinicians' SSH-related practice. Socialisation into existing professional cultures refers to the process of individual clinicians taking on, through "multiple continuous and ongoing processes", the values and norms of their discipline and learning to practice in a way that is aligned with these (Bloor & Dawson, 1994, pp. 278-9). These processes are both implicit and explicit. Implicit processes occur when neither those learning nor teaching cultural values and norms are fully aware of this 'hidden curricula' (Emmerich, 2015). Explicit processes include formal training and explicit acquisition of specific modes of thinking (Emmerich, 2015), for example specific ways of defining and consequently treating mental distress or illness. Clinicians draw on this cultural knowledge to understand how to be a professional within their discipline and make sense of daily workplace occurrences; and, in doing so, reproduce that culture (Bloor & Dawson, 1994). The socialisation of professionals into institutionally specific norms, values, and behaviours can be thus understood as the reproduction and reinforcement of the specific power relations and bodies of knowledge constituting these institutions (e.g., Conrad & Bergey, 2015; Lupton, 2012). From this perspective, mental health clinicians' approach and practice in relation to sexuality is not isolated from the

broader professional or institutional context, nor the historical and sociocultural context in which the institution itself exists.

Few studies that have explored sexuality-related practice in mental health settings have oriented directly to the wider institutional context, focusing instead on how clinicians' own understandings and practice choices produce sexuality-related silence. It is important to develop an understanding of the ways in which the wider institutional context(s) shapes mental health clinicians' understanding and practice in relation to sexuality. This will contribute to the broader literature that seeks to understand why sexuality and intimacy continue to be under-addressed in mental health settings, and how sustained improvements in relation to this might be best achieved. To this end, the analysis presented in this article explores specifically how participating mental health clinicians implicated the wider institutional context in which they learn and work in their accounts of (not) addressing sexuality within mental health settings and practice.

Method

The analysis presented in this article is part of a broader project that aimed to explore mental health clinicians' understandings of sexuality and sexual health, and their perceptions of addressing these in their work. The project was exploratory and qualitative in nature to facilitate an in-depth exploration of a topic that is still under-researched, particularly within Australian settings. A social constructionist perspective underpinned the project, where meaning is understood as being socially produced and knowledge is culturally and historically specific (Burr, 2015a). Moreover, language is understood as being active in this meaning-making process rather than a simple reflection of an independent reality or meaning (Burr, 2015a; Weedon, 1997).

The analysis presented in this article explores specifically how the institutional context in which clinicians learn and work shapes sexuality-related practice in mental health settings, according to participants' own accounts. We oriented to participants' talk as accounts (not a direct window to experience); but interpreted from these the kind of ideas or discourses that were available to participants in making sense of sexuality and sexuality-related practice in their work. This analysis therefore reflects participants' accounts of silence in relation to sexuality within mental health settings; but the focus is on when and how they implicated their workplaces, professions, and broader institution(s) within these accounts, both directly and indirectly.

Other studies that have explored sexuality within mental health settings have tended to focus on nursing practice (though there has been some research within psychology and psychiatry, e.g., Miller & Byers, 2012; White et al., 2019; Zatloff et al., 2020), be contained to specific sites or settings (i.e., psychiatric inpatient or community mental health settings: e.g., Brown et al., 2014; Ravenhill et al., 2020; White et al., 2019), or both (e.g., Higgins et al., 2008, 2009; Quinn & Happell, 2012, 2015a). This project explored the perceptions of clinicians from three disciplines (psychology, psychiatry, and mental health nursing) who were working across a range of mental health settings and sites in four Australian cities. Despite the diffuse nature of the participants' collective work environments (both in terms of geographic location and setting type), all participants belonged to three disciplines that are significant in their historical and ongoing roles as mental health professions in Australia and elsewhere.

Eight psychologists, six psychiatrists, and eight mental health nurses volunteered to participate in the project. Twelve participants identified as women and nine as men, and the

majority were of European descent. Participants ranged in age from 25–75 years old and in fully qualified professional experience from 2 months to 40 years[49]. Participants were working directly with individuals across a range of mental health settings including private practice (only psychologists and psychiatrists), community mental health, emergency departments (only psychiatrists and nurses), and inpatient settings (i.e., hospital or forensic settings). Many participants worked in more than one setting and three participants were working specifically in relation to some aspect of sexuality or sexual health.

Participants were recruited by advertisements circulated through professional websites and networks, including invitations distributed by two of the authors to members of their professional networks (ACH & CK) and via snowballing. Participation was not remunerated. The project was approved by the School of Psychology Human Research Ethics Subcommittee at the University of Adelaide (reference:15/107). All participants gave informed, written consent prior to commencing the interview. Participants selected or were assigned a pseudonym and transcripts were de-identified and anonymised. Most participants chose to receive and review a copy of their de-identified transcript. Three participants provided further clarifying remarks that were included in the dataset (with consent).

Interviews were conducted by the first author (KU) and lasted an average of 61 minutes (44–89 minutes). These were conducted face-to-face at participants' workplace or the authors' university, or via telephone, depending on both the participants' preference and location (18 face-to-face, 4 by telephone). Interviews were primarily participant-led but an interview guide served as an aide memoir to ensure that major topics of interest were always

[49] One nurse participant was still completing their graduate diploma in mental health nursing but very keen to participate. On review of the interview transcript, the authors agreed that this nurse's perceptions were not notably different to qualified mental health nurses and the data were included in the dataset accordingly.

discussed. These included participants' understandings of sexuality and sexual health, their conceptualisation of mental distress and illness, and their perceptions of addressing sexuality and sexual concerns in their work.

Interviews were audio-recorded and transcribed orthographically by KU in a cascading fashion; where scheduling permitted, each completed interview was transcribed before the next was conducted. Interviewing stopped when the authors agreed that subsequent interviews were not generating novel data (at a semantic level), either within or across profession groups. This was a pragmatic decision based on audit trail notes and ongoing discussion.

Consistent with the project's theoretical grounding, we used a form of critical reflexive thematic analysis to analyse the data (Braun & Clarke, 2006). This allowed us to attend to both semantic and latent content of the data in relation to our analytic interests, and to draw on various discourse analytic traditions where fruitful; for example, attending to "both the situated nature of accounts as well as the institutional practices and social structures within which they are constituted" (Burr, 2015a, p. 26. Also see Wetherell, 1998). Initially, the analysis explored sexuality-related silence in the data more broadly, since this was so common across participants' accounts. The authors familiarised themselves with the data and KU carried out inductive, semantic coding. During theme development and refinement, the authors decided to develop relevant overarching themes further in relation to two separate and more specific research questions. The analysis presented in this article was developed further to explore how participants implicated or drew on wider institutional discourses available to them to make sense of sexuality-related silence in their work. This involved a return to the raw data, modification of some codes and generation of new ones (including

latent codes), the (re)development of themes in relation to this more focussed analytic interest, defining and naming these themes, and finally producing the report.

The final themes presented in this article were discussed in detail by all authors, but KU made the final analytical decisions because she was most familiar with the data. The final themes are latent and inductive, but the analysis was not theoretically neutral (Braun & Clarke, 2006). Rather, it was informed by the epistemological assumptions and conceptual framework of the broader project, and by the authors' academic and clinical perspectives, knowledge, and positions (KU's academic training has been in Psychology but she is not a clinician; ACH is an endorsed health psychologist; CK is a sexual health physician).

Results

All participants talked about including or addressing various aspects of sexuality within their practice, at least occasionally. Despite this, SSH concerns were regularly omitted from everyday clinical practice. Participants often accounted for this by constructing sexuality as a topic that is difficult or embarrassing to talk about (including within the therapeutic encounter) and as peripheral to their professional responsibilities and to mental health settings more generally (explored elsewhere: see Urry, Chur-Hansen, & Khaw, 2019[50]). In talking about and making sense of sexuality-related silence in their work, participants also discussed (both directly and indirectly) broader silences that shaped and reinforced their own perceptions and practice choices; these were situated in their professional training, their workplace cultures, and in the tools, procedures, and policies that directed their practice. The workplaces and institutions in which participants learned and

[50] This is presented within this thesis in Chapter Six.

worked therefore also produced and maintained this peripheralisation and silencing of SSH in mental health settings; this is the focus of the analysis presented below.

Three themes were generated that capture the silencing of sexuality in mental health settings at the institutional level: *Relevant training is limited, lacking, or absent*; *Culture of silence*; and *Sexuality is "not embedded" in standard practice*. Extracts are provided to illustrate the analysis. Words added to the extracts to improve readability are in square parentheses and sections removed for brevity are indicated with […]. Words that were stressed by participants are underlined. To maintain anonymity, extracts provided in this article are denoted using participants' pseudonym[51] and discipline only. The setting in which a participant worked is also occasionally given to provide further context as necessary.

Relevant training is limited, lacking, or absent: "It was very much skimmed over" (Sandy, nurse).

According to participants' accounts, clinicians across all three disciplines are not well prepared through their professional education to address SSH within their clinical practice (e.g., pre-registration and specialisation education, and ongoing professional development). One psychiatrist participant perceived that SSH-related training within her professional education had been "pretty comprehensive". All other participants perceived that their SSH-related training during formal pre-registration or specialisation education was limited, lacking, or absent. SSH-related training was often perceived as having been specifically *inadequate*, and participants from all three disciplines talked about a need for additional

[51] Pseudonyms were purposefully selected for their traditionally gendered nature (in an Australian context) to reflect participants' gender identity.

education or training to support them in raising or addressing sexuality-related concerns within their clinical practice.

> I think in terms of sexuality, there needs to be more… um focus on sexuality when you're when you're learning about mental health because I think sexuality really impacts on people's mental health. […] we need to know [during professional education] at university about sexual health. Because there wasn't enough covered (Jake, nurse)

Participants did receive some formal SSH-related education, but this was most often in relation to very specific aspects or domains of SSH. These were generally biomedical aspects of sexual and reproductive health (psychiatrists and nurses), sexual function and sexual side-effects of medication (psychiatrists) or sex therapy (psychologists and psychiatrists), and sexual violence including child sexual abuse (all disciplines, but mostly psychiatrists and nurses). A few participants also recalled topics relating to cultural sensitivity regarding gender and sexuality diversity, though this was not perceived as having been covered well.

> we learnt about the reproductive tract, we learnt how to insert a catheter, we learnt how to take care of the genital area so very practical hands on things. But attitudes towards sex and sexual health and sexuality and sexual identity? It was very much skimmed over. I've learnt this on the job and from my own personal attitudes towards it. (Sandy, nurse)

The potential inclusion of broader aspects of sexuality such as intimacy, pleasure, or the right to sexual expression were notably absent in participants' accounts of their formal professional education (indeed, these were largely absent from many participants' accounts of

sexuality within the mental health setting overall). Participants' accounts indicated that their professional education about SSH focussed on and reinforced mostly medicalised and risk-oriented discourses of sexuality that constructed it narrowly as being about *sex* (i.e., penile-vaginal or, less commonly, penile-anal intercourse) and *risk*. This was echoed particularly clearly in one participants' account, a psychiatrist who had only very recently completed her advanced training (i.e., to qualify as a psychiatrist). Emma talked about having covered a wide range of sexuality-related topics in her training overall that included sex and risk but went beyond these to include relationships and gender and sexuality diversity. Despite this, Emma emphasised the experiential and unstandardised nature of this specialisation training. She perceived it as having been fragmented and potentially inadequate in relation to SSH:

> I think we're pretty good in our training to learn about you know the medications and the side effects and how to combat that. But sexual health more broadly is probably less consistent, it depends a lot on your supervisors and their understandings, your clinical experience, the types of patients that you're exposed to, that sort of thing. So I feel okay, but […] it probably means that there could be things that come up are probably quite challenging […] (Emma, psychiatrist)

A few participants felt that their formal SSH-related training had been limited but "enough" (Eric, psychiatrist), and that gaps in knowledge could simply be supplemented with continuing professional development (CPD) where necessary: "I think continuing medical education offers the opportunity to further expand that" (Ben, psychiatrist). Indeed, in the absence of comprehensive SSH-related training during formal professional education, many participants talked about having acquired knowledge about aspects of SSH from alternative sources including CPD, ongoing clinical supervision, and on-the-job experience. Clinicians

were therefore responsible for identifying gaps in their own knowledge and then taking a specific interest in broadening their knowledge about SSH within the mental health setting. This was demonstrated very clearly by Brett, a nurse in the final stages of completing his specialisation in mental health nursing. Brett perceived that he had received no direct education about sexual side effects of psychotropic medication but had identified this gap through working and was attempting to fill this himself:

> But [there's] nothing provided through training. […] a lot of the antipsychotics can affect sexual dysfunction and that would be one of the reasons for [non-] adherence to medications. So [I'm] trying to gather an understanding on the influence of antipsychotics on a client's sexual health. (Brett, nurse)

More broadly, many participants talked about having acquired their knowledge about SSH from their own lived experiences as teenagers and adults, and as members of society more generally. There was an assumption that clinicians will arrive at their formal professional education with pre-existing knowledge about sexuality, derived from their personal experiences.

> well I guess [I learned] through friends(?) like I've got quite a few friends who work in [a sexual health service…] so I just know… And obviously just being a grown man myself like I guess you just look at things on the internet. And obviously so I grew up in the eighties so like HIV/AIDS was like this massive epidemic (Jake, nurse)

Overall, there was a sense that that there are scarce opportunities for mental health clinicians to learn about sexuality through their professional education, particularly beyond biological functioning and risk. This dearth of training, in combination with the expectation that clinicians will simply 'learn it themselves' or arrive to professional education with

existing knowledge, acts to immediately peripheralise – and silence – sexuality within mental health settings and clinical practice.

Culture of silence: "it's not discussed very much at all" (Jake, nurse).

Within their accounts, participants tended to construct a culture of silence in relation to SSH that was located among clinicians in everyday practice and workplaces, and a broader ambiguous silence that was not located in specific instances of practice. Participants from all three disciplines (but predominantly nursing) regularly positioned sexuality or aspects of this as something that does not "get talked about enough" in mental health settings (Sandy, nurse), both within the therapeutic encounter (between clinicians and individuals) and among clinicians in the workplace. Participants' accounts implicated this culture of silence (directly and indirectly) in shaping their own and others' clinical practice in relation to SSH.

> I think it's probably something that uh… We don't ask about that much. Probably as a team. Or as a, I've worked with a couple of different teams so it's not just this team but uh as kind of a, public mental health system I think it's probably a bit um… […] I think we don't talk about sexuality as much as we should. When we're um assessing and treating. (Fay, psychologist)

Many participants positioned their own practice as being either aligned or in tension with this wider culture of silence. For example, some participants aligned their own SSH-related practice – or silence – with that of their colleagues to justify it as 'normal' or routine. Yvonne (nurse) demonstrated this neatly, positioning this silence as being (re)produced not only by herself and her nursing colleagues, but *also by* social worker colleagues within a multidisciplinary mental health setting. In doing so, she leveraged her colleagues' silence to protect both herself and her wider profession:

> We do sometimes [talk about sexuality] if we have like a clinical meeting a clinical review about a client. It might come up then. But not in general terms oh… Occasionally I do but it's, yeah and it's not just nurses it's social workers as well. Yeah I suppose occasionally I do yep. Not very often though. (Yvonne, nurse)

Many participants constructed a culture of silence in contrast to, or in tension with, their own practice that did include or orient toward aspects of SSH (according to their accounts). For example, Jake (nurse) repeatedly emphasised how he attempts to include aspects of SSH within his practice, positioning this as a unique way of practicing within his workplace. At other times during the interview, however, Jake aligned himself with this culture of silence, for example using the collective "we" to explain that sexual expression was only discussed among clinicians when it was being sensationalised as gossip.

> we don't really talk about sexual health very much at all in mental health, unless somebody is caught having sex on the ward and there's like "oh did you hear about that person having sex", obviously this is within the office context, but in terms of their sexual health no it's not discussed very much at all. (Jake, nurse)

Some participants (mainly psychiatrists and some psychologists) positioned their practice as siloed from others', rather than being shaped or constrained by it. These participants perceived their own practice as being distinct from their colleagues' (including colleagues' potential sexuality-related silence), and they discussed others' practice less often. This was in contrast to nurses, most of whom emphasised collective ways of working and regularly positioned their own practice in relation to sexuality as aligned or in tension with others' practice (and silence).

Nevertheless, participants from all disciplines constructed a wider culture of silence within their workplaces and professions. Often, this was constructed in a broad way and not located in any specific instance of practice. For example, SSH topics or needs were percieved as being "very easy to ignore if [psychologists] don't have an interest in it" (Claire, psychologist), echoing the idea discussed previously that clinicians need to have an interest in sexuality to access or seek out relevant learning opportunities. Other participants repeatedly suggested that clinicians need more awareness of how sexuality may be important in the lives of individuals experiencing distress, indicating that this is not currently "on the radar" for many clinicians (James, psychologist).

> It's not something that gets talked about a lot like it's covered at times in. med[ical] school and in psychiatry training but, compared to how big a part sort of sexual health might play in someone's life. Um I don't think that's equally represented in how much attention we pay to it in our practice (Emma, psychiatrist)

A culture of silence spanned all disciplines and setting types or workplaces, but some participant accounts challenged this. For example, some participants talked about how specific aspects of sexuality were regularly acknowledged and addressed in their workplaces. A nurse (Yvonne) described learning about the sexual side-effects of medication and how to incorporate this in her practice through "working with psychiatrists and other staff", indicating that at least this aspect of SSH was discussed within her workplace(s). One psychiatrist (Ben) argued that all of the psychiatrists (and psychiatry trainees) within his workplace knew to enquire about and address SSH-related concerns when relevant; but acknowledged that sexuality-related concerns "could be asked about more" when probed further. Indeed, despite accounts of specific aspects of SSH being addressed by some

clinicians or in some settings, there was an overall sense that "sometimes it does get glossed over a little" (Sandy, nurse).

Sexuality is "not embedded" in clinical practice (Fay, psychologist).

Participants regularly implicated the tools, resources, policies, and procedures available to them (or not) in their work when making sense of sexuality-related silence in mental health settings. Various tools, resources, and procedures were positioned within participants' accounts as failing to support or directly constraining clinicians' ability to identify, discuss, and address SSH-related concerns where appropriate and useful. Moreover, the presence of some procedures or policies was also sometimes perceived as directly constraining clinicians' practice in relation to SSH. These perceived material and structural constraints in relation to SSH within mental health settings indicated a lack of embeddedness of sexuality in everyday clinical practice.

Some participants (nurses and psychologists only) talked about a perceived absence of SSH-related topics within the tools that they used in their work, such as formal assessments or prompt sheets used for guiding and recording clinical interviews: "it's not a significant part of our assessment or our write up" (Dean, nurse). This absence was perceived as a constraint on clinicians' ability to confidently raise sexuality or sexual concerns with individuals because it indicated that SSH are "not really a part of standard practice" (Fay, psychologist). Some participants talked directly about how including relevant aspects of sexuality in assessment tools or other paperwork could potentially support clinicians to comfortably raise such topics by making the practice "more formal" (Jake, nurse).

Limited time resources were also positioned by some participants as constraining their ability to address SSH regularly or consistently in their practice. While this was occasionally

oriented toward rapport development (i.e., where the high level of trust required to facilitate discussions about sensitive topics is difficult to develop within a short timeframe), participants tended to position sexuality as something that was potentially too complex to address within a limited timeframe.

> Ethically I would need to be clear […] that there is adequate time to resolve any issues that may come up unexpectedly (Lucy, nurse)

Time constraints are a challenge faced by all clinicians providing publicly funded health services (Dyer & das Nair, 2013; East & Hutchinson, 2013), and they can also be used as a justification to avoid uncomfortable or complex conversations including in relation to SSH (e.g., Ussher et al., 2013). Within these data, SSH-related issues were topics that were 'allowed' to be avoided or disregarded due to time constraints. This was positioned as being very normal, across disciplines and settings. Some participants also oriented to time constraints as a main reason that sexuality is not included adequately within professional education, within both formal curricula and the public mental health system more broadly (i.e., where psychiatrists receive much of their training). This indicates that the broader norms of participants' workplaces or professions permitted SSH to be avoided or disregarded due to time constraints, rather than positioning this as an integral part of comprehensive mental health care that demands time allocation.

> and you know sometimes I'm guilty of getting busy and not focusing on that and focusing more on other issues that seem more important at the time. […] in a public system where a lot of the care is now episodic even for chronic illness you may only be seeing people in those times of crisis so you might not be building the relationship up to remember to ask, to think to ask, to have time to ask about all of those other

> factors that are obviously really important but don't always take precedence when you first meet somebody. (Emma, psychiatrist)

Participants also described the presence of procedures and policies within their workplaces or the mental health system that they perceived as directly constraining their practice in relation to SSH, including sexuality (and gender) diversity. For example, Lucy (nurse) reported that she was "not supposed to ask directly" about individuals' sexuality identity, which constrained her ability to fully understand individuals' situation and to build a safe, open exchange. In contrast to this, Dean (nurse) described in-service training and procedures within his workplace that were intended to support staff in working appropriately with individuals who are gender and sexuality diverse. Despite this, he explained that clinicians, including himself, chose not to adhere to these procedures consistently because these were sometimes perceived as negatively impacting broader practice including rapport development:

> at a training day we were encouraged to introduce our self [to individuals] as 'my name's [Dean] I identify as male what's your name and how would you like to be identified?' […] we work a lot with developing rapport and a therapeutic relationship in the short amount of time we've got, so you really wanna kind of, give a good first impression and saying something odd like that would [not support that goal] (Dean, nurse)

Clare (psychologist) shared a story about the team in her workplace, a rehabilitative forensic unit, introducing flexible check-in procedures to support an individual who wanted to go on dates during his community visits (the individual was allowed to update staff on his location via texts instead of phone calls, which he preferred). These clinicians' ability to

amend procedures to support individuals' relationship and intimacy needs contrasted with other participants' accounts of inflexible or limiting workplace procedures. Nevertheless, Claire's account was one of the few instances within the dataset in which workplace procedures or institutional policy was positioned as facilitating clinical practice that supported individuals' sexuality or relationship needs beyond a risk-orientation (e.g., a focus on risk of disease transmission, unplanned pregnancy, or sexual violence). This represented a notable absence in itself: when participants implicated the wider institution in their accounts of addressing sexuality or not, they generally positioned this as constraining their efforts or, more broadly, as silencing sexuality. This was illustrated clearly in participants' accounts of navigating sexuality and intimacy needs within mental health settings, especially in inpatient settings where individuals are usually perceived as lacking the ability to give sexual consent. Perceived ability to consent to sex is a complex issue. Within participants' accounts, institutions responded to this complexity in a way that was prohibitive and risk averse. Relevant procedures available to participants did not include or facilitate a careful consideration of individuals' needs and desires, or an opportunity to discuss sexuality and intimacy concerns in a supportive and dignified manner.

> just last week though we had a gentleman who was manic, his wife was in visiting him on the ward […] some of our staff found both him and her together in a bed, him just wearing his underwear [so] was that appropriate or not? They were asked to, get out of the bed and to put their clothes back on […] (Josh, psychiatrist)

Most participants who worked in inpatient settings commented on (or discussed at length) the presence of 'no sex' policies within those settings, which were often perceived as functioning to maintain individuals' safety and dignity. But these policies, and the procedures

involved when individuals did engage in sexual activities, also constrained participants' ability to respond to individuals' sexuality and intimacy needs beyond safeguarding efforts. So, while the institution did orient toward sexuality within some mental health settings, the focus was on simplified risk-avoidance and repair, with the complexity of the situation potentially evaded. This was well illustrated by one psychiatrist's story about working with two individuals in a psychiatric ward (involuntarily) and who had been found out to have had sex:

> there were all the medicolegal issues and the hospital wanting to cover itself and I found that the patients got lost. In that it became all about risk management and procedure […] rather than actually looking at. How do these people actually feel about this and is that going to change, and how does it affect their relationships, and do we talk to their family about it or do we not talk to their family about it (Emma, psychiatrist)

Risk aversion at an institutional level was echoed in one psychologist's (Nick) account of his workplace's orientation toward sexuality. Nick's account represented an exception within the dataset overall: Addressing individuals' sexuality and relationship concerns was embedded in clinical practice via prompt sheets, assessment tools, and regular conversations among clinicians in relation to individuals' sexuality needs[52] (this was not a setting that specialised in aspects of SSH). While this workplace supported clinicians to address a range of SSH-related concerns (including intimacy and relationship concerns), it was also strongly oriented toward facilitating 'safer sex' in particular. There was therefore a

[52] Interestingly, towards the end of the interview KU suggested that it sounded as if Nick raised aspects of sexuality in almost every therapeutic encounter; he agreed but commented that he had "never thought of that" before.

primary focus on risk avoidance in relation to disease and pregnancy, and this is notable within the wider context of this dataset and analysis.

Discussion

Sexuality-related silence was common across the data and, in accounting for this, participants not only positioned sexuality as a socially embarrassing topic that is peripheral to their everyday practice (Urry et al., 2019), but implicated the broader institutional contexts in which they learn and work. The analysis presented here indicates that sexuality-related silence in mental health settings is produced and reinforced at the institutional level in several ways. First, the limited provision or availability of relevant professional education functions to position sexuality as peripheral within mental health practice, except where there may be perceived vulnerability or risk to identify and manage (e.g., in relation to transmission of disease, unplanned pregnancy, and sexual violence). This peripheralisation is then reinforced and maintained within many mental health settings through a wider culture of silence among clinicians and by a lack of embeddedness of sexuality within tools, procedures, and policies that facilitate clinical practice.

Similar structural and material constraints on clinicians' sexuality-related practice have been identified across health settings, including a dearth of relevant professional education, time pressures, and the absence of sexuality in formal tools and checklists. These are often interpreted by researchers as barriers that negatively impact clinicians' comfort and competence in addressing SSH (e.g., Hendry et al., 2018; Hughes et al., 2018; Quinn & Happell, 2012) or as justifications that work to locate omissions of sexuality beyond the individual clinician's control and therefore responsibility (e.g., Ussher et al., 2013). Indeed, participants' accounts in the current study might also achieve this justificatory function and

the analysis presented here could be interpreted similarly. In orienting directly to the role that the wider institutional context plays in shaping clinicians' understandings and approach to sexuality, however, these accounts can be understood as more than 'just excuses' for inadequate practice by individual clinicians. Rather, they can be understood as the reproduction of broader institutional discourses that serve to silence sexuality by shaping clinicians' understandings of and approach to SSH.

A dearth of relevant training is commonly identified as a barrier for clinicians to raising or addressing aspects of SSH across various health and mental health settings (e.g., Dyer & das Nair, 2013; East & Hutchinson, 2013; Hughes et al., 2018; Quinn et al., 2011b; White et al., 2019). In this study, and consistent with previous research, sexuality topics were largely absent from psychologists' professional education while nurses' and psychiatrists' sexuality-related training tended to be narrowly focussed on medicalised aspects of sexuality including disease and reproduction, physical sexual (dys)function, and risk (e.g., Higgins et al., 2009; Miller & Byers, 2012). Beyond simply producing a skill deficit, the absence of comprehensive education, including the narrow breadth of this education when it is made available, produces particular ways of thinking about and understanding sexuality within the context of mental distress and illness. There is some evidence that the presence (or absence) of sexuality-related topics in professional education may play an important role in directing how clinicians will go on to (de)prioritise those topics and perceive them as being (ir)relevant within their work (Miller & Byers, 2012; also see Quinn & Happell, 2012). A dearth of relevant professional education indicates that, at an institutional level, sexuality is immediately positioned as being peripheral to mental health care and clinical practice within mental health settings.

The notable absence of pleasure, wellbeing, sexual rights, and intimacy and relationship needs within participants' accounts of their sexuality-related professional education has been observed elsewhere. For example, Higgins and colleagues (2009) reported that there was no evidence to indicate that mental health nurses in their study had learnt about or been exposed to discussions about sexual rights or the sexual and intimacy needs of people experiencing mental distress. Rather, the professional education provided to nurses in their study had emphasised pathological sexuality, providing only a negative framework for thinking about and responding to sexuality within the mental health setting (Higgins et al., 2009). A similar pattern was observed in this study where participants' accounts indicated that sexuality-related professional education, when it was provided, was presented through largely medicalised and risk-oriented discourses that construct sexuality narrowly as being about *sex* and *risk* (also see Astbury-Ward, 2011; Irwin, 1997; Stelzl, Stairs, & Anstey, 2017). This reinforces constructions of individuals experiencing distress as either disinterested in sexual expression and intimacy or sexually dysfunctional or pathological (Higgins et al., 2009), limiting clinicians' ability to adequately incorporate sexuality into their practice beyond these concerns.

Despite a clear need to improve mental health professional education in relation to sexuality, focusing on this *alone* may not affect successful and sustained change in clinical practice. The analysis presented here indicates that the initial silencing of sexuality within professional education is reinforced by broader processes of socialisation to which clinicians are exposed within their workplaces and professions. Newly qualified clinicians move into an existing professional culture and continue to learn from their (senior) colleagues[53] (Bloor &

[53] This includes clinicians who work in individual settings, for example psychologists engage in ongoing supervision and mentoring with peers and senior colleagues (Miller & Byers, 2012; Riessing & Di Giulio, 2010)

Dawson, 1994; Higgins et al., 2009). This modelling contributes to the ongoing 'hidden curriculum' that reproduces a broader culture of silence within workplaces. Though participants in this study generally did not directly discuss vicarious learning, many did construct a wider culture of silence in relation to sexuality within their workplaces, professions, and even the wider mental health system. This culture of silence constrained their own and others' practice or could be drawn on to explain or normalise their own and colleagues' omissions of sexuality within everyday practice. This was further reinforced by the absence of material and structural supports to incorporate sexuality into clinical practice, and by the presence of risk-oriented policies and procedures that constrained participants' ability to respond to individuals' sexuality needs beyond safeguarding measures. Individual clinicians are not necessarily able to challenge or adapt existing ways of working within a setting, particularly if the prevailing approach to sexuality is largely one of avoidance or risk aversion. Rather, they become inculcated into existing ways of approaching – or silencing – sexuality within their clinical practice.

This institutional silence built up in participants' talk is situated and active, working to produce and reinforce broader discourses within both mental health settings and wider society. People experiencing mental distress or illness have historically been excluded from normative sexuality and expression (e.g., see Perry et al., 2018). Sexuality-related silence within mental health settings, particularly at the institutional level, acts to further limit or delegitimise the sexuality of people engaging these services. This silence therefore does not *ignore* sexuality in a passive manner but, rather, constructs it in a way that makes sexuality, intimacy, and sexual expression largely unavailable within the context of mental distress, beyond pathologizing discourses (also see Higgins et al., 2008, 2009). In this way,

institutional silencing of sexuality can be understood as a form of "management by non-recognition" (Shildrick, 2009, p. 64).

Silencing (or pathologising) sexuality may also function to make the management and delivery of mental health services easier, though not necessarily ethically responsible. For example, silencing sexuality may render this "more manageable" by reducing the variability in how individuals might raise, relate to, or express sexuality within the mental health setting or their broader experience of distress, particularly within inpatient settings (Brown et al., 2014, p. 252). The absence of supportive policy regarding sexual expression and needs can make it difficult for clinicians to navigate professional boundaries and responsibilities, forcing clinicians to draw on their personal experiences and understandings to make clinical judgements (Ravenhill et al., 2020; White et al., 2019). In the current study, participants working in inpatient settings had difficulty in navigating the presence of prohibitive, risk-oriented policies regarding sex and sexual expression. Indiscriminate prohibition of sex and sexual expression (beyond masturbation) in inpatient settings is common; but this is not supported by human rights law, mental health law, criminal law, or duty of care (in the context of Victoria, Australia: Maylea, 2019). Clinicians need to be better supported to respond lawfully and ethically to individuals' sexuality needs and to provide support accordingly. The practicality of responding appropriately to individuals' sexuality-related needs in (acute) inpatient settings poses a complex challenge but, as Maylea (2019) has argued, it is one with which clinicians and policy makers have a duty to engage.

It is important to recognise that while clinicians' understandings and practices are shaped by the institution, they also simultaneously reproduce this silence through their practice choices (Urry et al., 2019. Also see Higgins et al., 2009). Processes of professional

socialisation are not deterministic (Clouder, 2015; Emmerich, 2015) and the challenges created by the broader institutional context are not immutable (e.g., Ussher et al., 2013). Despite this, the institutional context does need to be acknowledged and understood within research that seeks to improve sexuality-related practice in mental health settings.

Orienting within research to the ways in which sexuality is constructed and addressed (or silenced) at the institutional level through discursive, structural, and material configurations is useful in two main ways. First, this contributes to understanding why individuals' sexuality and intimacy needs continue to be unmet in mental health settings, despite the development of communication models and educational interventions aimed at increasing clinicians' knowledge and competence (see Quinn & Happell, 2012). An institutional approach can sit alongside research that focuses on clinicians' knowledge and competence to produce a more nuanced understanding of the overall problem, as demonstrated by the current study. Second, and related to this, a better understanding of the ways in which sexuality-related silence is produced and maintained at the institutional level offers another route through which change can be effected.

The analysis presented in this article has demonstrated the need to orient toward the institutional context in research that seeks to understand why sexuality is not adequately addressed within mental health settings. This supports limited existing research indicating that interventions to improve sexuality-related clinical practice need to target the broader contexts in which clinicians work, rather than focusing solely on clinicians themselves studies (e.g., Hughes et al., 2018; Ussher et al., 2013; White et al., 2019). The success of interventions that aim to increase clinicians' knowledge, perceived competence, and comfort in incorporating sexuality into their practice may thus depend on embedding these in entire

workplaces and on introducing workplace or system level policy to facilitate an environment that supports clinicians to this end. This is not to argue that efforts to improve clinicians' knowledge, competence and comfort should be curtailed. Rather, these efforts need to be supplemented or broadened away from clinicians as isolated practitioners. Researchers, educators, and clinicians themselves (especially those in management, senior, and supervisory positions) need to recognise that clinicians' practice is shaped by the broader institutions and cultures in which they work.

Conclusion.

This article has contributed to the wider literature that explores SSH within mental health settings, particularly mental health clinicians' sexuality-related practice. The analysis demonstrates that institutions shape the ways in which clinicians can approach and respond to sexuality within mental health settings, according to their own accounts. We have argued that sexuality-related silence in mental health settings is therefore not located wholly in individual clinicians' *deficits*. Rather, it is produced within the broader institutions where clinicians learn and work. In orienting to this broader context, it seems redundant to continually (and only) ask why mental health clinicians do not address individuals' sexuality and intimacy needs. We propose that research and interventions should focus on enriching the broader context to better support clinicians to incorporate sexuality and sexual concerns into holistic, recovery-oriented mental health care.

CHAPTER EIGHT: Discussion, Recommendations, and Conclusions

8.1 Introduction

This thesis explored sexuality and sexual health in mental health care settings through the perceptions of psychologists, psychiatrists, and mental health nurses in Australia. The overarching aim of the project was to explore and better understand how mental health clinicians understand and orient toward (or away from) sexuality and sexual health in their work. To address this aim, I conducted an exploratory, qualitative study grounded in a broadly social constructionist approach and a critical methodological framework (outlined in sections 2.2 and 2.3). One dataset was generated from in-depth interviews with psychologists, psychiatrists, and mental health nurses working across a range of settings in four metropolitan areas in Australia. Multiple analyses were conducted using this dataset via critical thematic analysis, each in relation to a specific research question that linked to the broader project aims.

Asking multiple questions of one dataset allowed me to approach and explore the data using different theoretical lenses or analytic foci. This enabled the production of multiple, layered interpretations of the same data that sit both alongside and in tension with one another, and that each make useful contributions to the wider literature. This focus on theory and depth of interpretation, as well as the inclusion of self- and methodological reflexivity, demonstrates strong rigour and trustworthiness of the research (also see section 2.6.1). Indeed, many scholars have emphasised the need for qualitative research to interpret data and generate insight into phenomena, rather than merely describe them, both within thematic analysis (e.g., Braun et al., 2019) and qualitative health research more broadly (e.g., Chamberlain, 2000; Yardley, 2000). This thesis therefore represents a contribution to the area

of sexuality and mental health and to the disciplines of critical and critical health psychologies.

This is the first study to explore the sexuality-related perceptions of mental health clinicians working across multiple disciplines, settings, and sites within an Australian context. As discussed in Chapter One (section 1.4.2.), much of the existing relevant research has been conducted in relation to mental health nurses, within inpatient settings, and in countries other than Australia. Relevant Australian research has been focussed on mental health nurses working within single sites (inpatient and outpatient/community mental health settings: Quinn, 2013; Quinn & Happell, 2015a-c). The results presented in this thesis largely support and extend, rather than disagree with, the existing literature. This indicates that mental health clinicians' perceptions of sexuality are similar across disciplines including those less researched, like psychology, and (Westernised) cultural contexts including Australia, Canada, Ireland, and the United Kingdom.

The research presented in this thesis also challenges the pervading biological and risk-oriented approach to sexuality that has been identified both within health and mental health contexts (e.g., Evans, 2011; Higgins, 2007b; McCann et al., 2019; Ussher et al., 2013) and more broadly (e.g., Barker et al., 2018; Fahs & McClelland, 2016; Loeser et al., 2017; Teifer, 2006; Shildrick, 2009). This pervading approach is limiting and potentially harmful because it reproduces medicalised understandings of and responses to sexuality. In contrast, I adopted a constructionist, critical health psychology framework within this thesis that allowed me to ground the project in an assumption that sexuality and sexual health are best understood within mental health settings as broad, multifaceted concepts that go beyond biology, bodies, and risk (outlined in section 1.2). This also enabled me to approach sexuality within mental

health settings in a way that centred and reflected individuals' self-identified needs (discussed in section 1.3.3.), rather than privileging clinical concerns about pathology and risk.

I have embedded reflexive considerations throughout this thesis, in relation to both myself as situated researcher and to the ongoing methodological choices that I have made throughout the project. This reflexive work, especially as it is presented in Chapter Three, contributes to demonstrating the trustworthiness and rigour of the analyses and interpretations presented in this thesis (Tracey, 2008; Yardley, 2000. Also see sections 2.6.1. and 2.6.3.). Chapter Three presented an in-depth reflexive account of how nondisclosed sexual identities may shape and constrain data generation within qualitative interviews. As a novice interviewer at the outset of this project, the literature exploring qualitative interviewing methods, difficulties, and dilemmas was invaluable to my preparation for, and development of skills throughout, data generation. The manuscript presented in Chapter Three contributes to this literature and, I hope, will support others in navigating similar dilemmas in relation to non/disclosure and (sexual) identity in the field. This reflexive account also provided a context through which to understand how the data in this study were co-generated and, later, interpreted.

The concluding discussion presented in this chapter brings together the results from all four analyses, presented in Chapters Four to Seven and summarised below, to discuss their major contributions to the literature. I then present recommendations for practice and future research regarding sexuality and sexual health in mental health settings based on a synthesis of the results of this thesis with the existing literature. I also consider some important limitations of the current study along with the opportunities for future research that these present, before concluding with some final remarks.

8.2 Overview of the Analyses

The analysis presented in Chapter Four provided a rich description of participating clinicians' conceptualisations of sexuality and sexual health within interviews. Participants' conceptualisations were varied and not bound by profession, but could be loosely organised into two major themes that were nested: Sexual health is *all about sex* and *more than just having sex*. Most participants' conceptualisations of sexual health were grounded in the former, a reductionist approach where there was a focus on sex (i.e., intercourse) and the body. Accordingly, sexual health was primarily understood as biological and physical safety in relation to sex, genitalia that functioned normally to achieve climatic sex, and sexual desire that was appropriate or 'normal'. This conceptualisation was also largely heterocentric because of the defaulted focus on *hetero*sex (i.e., penile-vaginal intercourse). Participants' also conceptualised sexual health as *more than just having sex*, expanding beyond biology and bodies to include intimacy, relationships, and emotional safety. However, these expanded aspects were nebulous, and participants had difficulty articulating sexual health within this broader conceptualisation. Moreover, these aspects of sexuality and sexual health often remained at the periphery of participants' conceptualisations, particularly when they were discussing sexual health within the mental health setting specifically. The term 'sexuality' tended to be understood in terms of sexual identity or orientation, and sexual identity was only discussed in relation to non-heterosexual identities; this functioned to position heterosexuality as a silent norm (Kitzinger, 2005) and was aligned with the heterocentricity of participants' talk.

There was a preoccupation with risk and danger regarding sexual expression within the context of mental distress. Participants tended to perceive sexuality and sexual health concerns as being relevant within the context of mental health service provision when there

was also some form of associated risk. This was explored in the published manuscript presented in Chapter Five. Two main patterns were generated regarding perceived sexual danger which draw on a neoliberal framework of (sexual) health as something achieved by self-regulating individuals: *Sex(uality) as dangerous* and *Individuals as sexually dangerous*. Participants had difficulty in determining when and how an individual might be autonomous or not, and therefore sexually dangerous or not.

Sexuality was largely omitted from participants' everyday practice, and this was common across most participants' accounts. This was despite reports from all participants that they did talk about or raise some aspects of sexuality or sexual concerns in their practice, at least occasionally. In the published manuscript in Chapter Six, I demonstrated that participants across all three disciplines tended to make sense of and account for omissions of sexuality by deprioritising it and locating it outside of their professional responsibilities and the mental health setting more generally (*Sexuality is a "peripheral issue"*). In making sense of sexuality-related silence in their work, participants also discussed broader silences that shaped and reinforced their own perceptions and practice choices, and this was explored in Chapter Seven. I demonstrated how the institutional context in which participants learn and work shaped sexuality-related practice, and I argued that workplaces and institutions produce and maintain the peripheralisation and silencing of sexuality that was explored in Chapter Six.

8.3 Major Contributions to the Literature

This thesis makes several contributions to existing sexuality and mental health care literatures, many of which have been discussed in the discussion sections in Chapters Four through Seven. Three major contributions are discussed in this section. First, the exploration

of participating clinicians' conceptualisations of sexuality and sexual health, presented in Chapter Four, is novel and makes an important contribution to the wider literature. Second, results from several analyses indicated that risk-oriented and silencing practices are the primary responses to sexuality and sexual health within mental health settings, and these limit opportunities to identify and respond to individuals' sexuality and intimacy needs. Third, the analysis presented in Chapter Seven demonstrated how the wider institutional context in which participants learned and worked was implicated in producing and reinforcing the dominant risk-oriented and silencing practices. This orientation toward the broader institution is less common in the wider literature and it has important implications for how researchers, educators, and clinicians move forward to ensure that individuals' sexuality, intimacy, and relationship needs are better addressed within mental health settings.

8.3.1. Conceptualisations of sexuality and sexual health: A novel contribution.

The analysis of mental health clinicians' conceptualisations of sexuality and sexual health presented in Chapter Four represents a major novel contribution of this thesis to the wider literature. Mental health clinicians' conceptualisations of these concepts have rarely been explored directly, despite consistent identification of a dearth of appropriate professional education and, related to this, an implied lack of knowledge about sexuality as it is relevant within the lives of people experiencing mental distress (discussed in section 1.4). The analysis demonstrated that there was variation in participants' conceptualisations within and across disciplines, but core to most of these was a primary focus on sex, biology, and bodies. That is, conceptualisations of sexual health were primarily biomedical, reductionist, and risk-oriented. They were also largely hetero-centric. Moreover, the analysis indicated that participants drew on common cultural discourses of sexuality and gender, discipline-specific (professional) knowledge or approaches, and non-professional knowledge and experiences in

making sense of sexuality and sexual health within interviews. Thus, all participants' knowledge about sexuality and sexual health was embedded in sociocultural, professional, and personal systems of meaning (Kleinman, 1980; Lupton, 2012).

These findings provide a framework through which to interpret or better understand clinicians' reported perceptions of or responses to sexuality and sexual health concerns within their work, as reported in this thesis and in other studies. The way that clinicians conceptualise sexuality shapes how they identify, respond to, and address or 'treat' sexual concerns within the therapeutic encounter (Epstein & Mamo, 2018; Kleinman, 1980; Weeks, 2010). A conceptualisation of sexual health as primarily *all about sex* is congruent with a risk-orientated approach to sexuality within mental health settings more broadly, as identified in this thesis (discussed below) and other studies (e.g., de Jager & McCann, 2017; Hughes et al., 2018; Quinn et al., 2018). Similarly, the silencing or disregarding of sexuality within health and mental settings, also reported in this thesis and elsewhere (e.g., Higgins et al., 2008; Quinn et al., 2011a; Ussher et al., 2013), can also be understood as a somewhat practical response within contexts where it is assumed that individuals are *not* having sex (i.e., whether this is because they are in an inpatient setting or, within community settings, simply have not reported that they are involved in an intimate or sexual relationship). Participants did construct sexual health as *more than just sex*, but this conceptualisation was less articulated, indicating that it may also be difficult for clinicians to act on translate this into their practice. Exploring how clinicians conceptualise sexuality and sexual health, as done in this thesis, can therefore provide a deeper understanding of why they approach or respond to sexuality within their practice in particular ways. In turn, this will support the development of successful interventions to improve sexuality-related care in mental health settings.

8.3.2. Risk/silence: A dominant approach at the individual level.

There were two primary responses or approaches to sexuality and sexual health within mental health settings demonstrated in this thesis: turning *toward* sexuality as an explicit risk or pathology that required surveillance and management, or *away* from it as something that was imagined to be lacking priority, irrelevant, or to not exist within the context of mental distress and illness. The oscillation between these approaches to sexuality within participants' accounts was demonstrated throughout the analyses presented in this thesis (including Chapter Seven, but the focus in this argument is on perceptions and practice at the level of the individual clinician). In somewhat of a contradiction, both responses were both facilitated by, and demonstrated through, the dominant focus on sex, biology, and bodies in relation to sexuality and sexual health discussed above. That is, the a medicalised, sex-centric conceptualisation of sexual health was used by participants to both *pathologise and centre* and *peripheralise and ignore* sexuality within their clinical practice, according to their accounts.

The common risk-orientation and silencing described above both constitute forms of management, by pathologising or refusing to recognise sexuality respectively (Shildrick, 2009: also discussed in Chapter Seven). Together, these explicit and implicit management strategies in relation to sexuality reproduce stigmatising or harmful discourses that position individuals experiencing mental distress as either (or both) hypersexualised, predacious, and risky, or unable to engage in 'normal' sexual experiences or intimate relationships, respectively (Higgins et al., 2008; Shildrick, 2009). The continual turning *away* from sexuality within participants' accounts of theirs and their colleagues' clinical practice, except where pathology, perversion, or risk could be identified and managed, therefore positions sexuality as something that does not belong within experiences of mental distress, or mental

health settings, except where it can be carefully managed and controlled (Brown et al., 2014). This may constitute another, more implicit conceptualisation of sexuality and sexual health within mental health settings that is more aligned with historical exclusionary discourses (discussed in section 1.2.3.) than with current claims to recovery-oriented mental health care (Australian Government, 2013a-c).

The argument and relevant findings discussed above contribute to the existing critical literature demonstrating that current (mental) health practice and discourses contribute to reproducing wider harmful discourses that render sexuality abnormal or unavailable in the context of mental distress, disability, and difference or non-normativity (e.g., Barker et al., 2018; Higgins et al., 2008; Loeser et al., 2017; Shildrick, 2009). This is also directly relevant to the mental health literature, where the risk/silence approach(es) limits clinicians' opportunities to understand and support individuals in relation to sexuality, intimacy, and relationship needs that may impact on their sense of self or experience of distress, or both (e.g., Deegan, 1999; McCann et al., 2019; Tennille & Wright, 2013). In this way, a focus on biomedical and risk issues in relation to sexuality comes at the expense of developing an understanding and practice in relation to broader and positive aspects including intimacy and relationship needs. Indeed, there was a broad silence in the data regarding pleasure, wellbeing, and sexuality beyond sex and biology more broadly, as indicated across multiple analyses in this thesis. This indicates that individuals' sexuality-related needs, as they have identified them (described in section 1.3.3.), continue to be largely unmet.

8.3.3. Risk/silence: A dominant approach at the institutional level.

The wider institutional context in which participants learned and worked was also implicated in producing and reinforcing the processes of managing sexuality within mental

health settings by turning toward this as risk or away from it as a peripheral or irrelevant issue. This was demonstrated in Chapter Seven where, according to participants' accounts, wider institutional discursive, structural, and material configurations shaped and constrained how clinicians are able to conceptualise, approach, and respond to individuals' sexuality and sexual health needs. Compared with a focus on clinicians and their knowledge and competence, this wider institutional context has been less commonly acknowledged or oriented toward in research that aims to understand and improve how sexuality and sexual health are addressed within mental health settings (see Chapter Seven). The critical, constructionist framework underpinning this project enabled me to examine this institutional context closely, and this represents a major contribution to the literature and extension to current knowledge about sexuality and sexual health in Australian mental health settings. The significance and implications of this, in relation to the broader findings of this study and the wider literature, are discussed below and in the next section.

Using insights from the analysis presented in Chapter Seven as a lens through which to interpret the results of other analyses presented in this thesis, participants appear to conceptualise and respond to sexuality and sexual health in ways that are largely congruent with the wider institution(s) in which they learn and work. The wider institutional environment shapes clinicians' practice by constraining and facilitating particular ways of perceiving and responding to health and illness experiences (Kleinman, 1980; Lupton, 2012). In relation to sexuality, mental health clinicians in this and other studies appear to be largely constrained through absent or limiting relevant professional educational (where reductionist and pathologising discourses are dominant: Higgins, 7007b; Higgins et al., 2009; Stelzl et al., 2018), a culture of silence in the workplace (Higgins et al., 2009), a lack of embeddedness of sexuality within everyday practice (e.g., Hughes et al., 2018; White et al., 2019), and a broad

risk-orientation toward sexuality at the organisational level (e.g., Brown et al., 2014; Quinn & Happell, 2015c; Ravenhill et al., 2020). The broader cultural discourses of sexuality that participants drew on in conceptualising sexuality and sexual health (i.e., normative and heterocentric discourses of sex) also appeared to be reinforced, rather than challenged, at the institutional level. In this way, broader institutional and social discourses of sexuality can be understood as being 'played out' at the individual level through participants' perceptions and accounts of everyday clinical practice (Guilfoyle, 2003).

Other relevant research can also be interpreted differently by orienting toward the workplace or institutional context beyond the individual clinician. For example, an Australian study reported that brief education sessions with mental health nurses worked to generate sustained improvements in practice over two years (Quinn, 2013; Quinn & Happell, 2012). The education sessions were provided individually, but the study was conducted across three settings within a single service. Given that the intention of the study was to change the nurses' practice, it seems likely that they would have discussed their participation in the project with one another as well as with non-participating colleagues. The service also had to agree to participate in the long-term study, indicating that there was interest in the project and its aims at a management level. Accordingly, the project may have generated (or been part of) a wider, positive shift within the culture of that service in relation to sexuality. The reported improvements in practice over time following the education sessions may therefore have been generated through a cultural shift within the service in addition to, or even instead of, improved clinician knowledge specifically. Understanding the relative contributions of these would be helpful for future intervention development or implementation. However, as the authors did not orient toward this wider context, the specific contributions of the individual education sessions cannot be teased out from a potential shift in the wider workplace culture.

A narrow focus in research on individual clinicians' knowledge and competencies to the exclusion of the wider institutional context works to invisibilise and reinforce the institutions' complicity in pathologising and silencing sexuality within mental health settings. This obscured complicity, explored in this thesis, can help to explain why ongoing calls for improved sexuality-related care in mental health settings – including the development of brief educational and communication interventions for clinicians – have not facilitated systemic and sustained improvements, as evidenced by the continued inadequacy of this care (e.g., McCann et al., 2019). Within the broader discipline of nursing, for example, the importance of sexuality within nursing practice has been identified, discussed, and researched for over two decades (e.g., Kautz, Dickey, & Stevens, 1990; Irwin, 1997); but it continues to be inadequately included in pre-registration education (e.g., Astbury-Ward, 2011) and clinical practice across health settings (e.g., East & Hutchinson, 2013; Katz, 2005b; Odey, 2009). The research presented in this thesis suggests that mental health clinicians who are, or could be, open to incorporating sexuality in their practice currently learn and work within broader environments that do not similarly value sexuality as part of holistic, recovery-oriented mental health care nor conceptualise sexuality in a broad, affirmative manner. This thesis has contributed to developing a more nuanced understanding of how sexuality is constructed as a risk requiring management or silenced and rendered largely unavailable within the context of mental distress by both clinicians *and* the wider institution. This can facilitate the development and implementation of more effective interventions to improve how sexuality and sexual concerns are identified and addressed within mental health settings. To this end, several recommendations for practice and research are outlined in the next section.

8.4 Recommendations for practice and research.

The results presented in this thesis support previous research indicating that there is a need to increase mental health clinicians' knowledge, comfort, and competence in relation to sexuality and sexual health, how this may be relevant within the lives of people accessing mental health services, and how this can be better incorporated into everyday clinical practice. The results also indicate that this cannot be achieved by focusing directly on clinicians as if they are isolated from their environment. Rather, there is a need for *multilevel* interventions to achieve effective and sustained improvements in the way that sexuality and sexual health-related needs are identified and addressed within mental health settings. To this end, I present four main recommendations based on the research presented in this thesis and the existing literature. These are discussed below. First, relevant professional education at all levels must be increased and efforts made to ensure that this is comprehensive and supports students and clinicians to identify, interrogate, and challenge dominant (and limiting) understandings of sexuality and sexual health. Second, there is a need to improve the tools, policies, and procedures available to clinicians within workplaces to facilitate the translation of knowledge and competence into practice. Third, mental health practice guidelines should be made clearer regarding sexuality and sexual health, including how these should be addressed by mental health clinicians and services. Fourth, there is a clear need for expanded research foci and activities that better align with affirmative conceptualisations of sexuality and sexual health, recovery-oriented mental health care provision, and the sexuality-related needs and desires of individuals experiencing mental distress.

Importantly, none of these interventions or approaches are intended to be taken up in isolation. Clinicians' understandings and perceptions of sexuality and sexual health are simultaneously informed by and perpetuate social structures and processes within healthcare

systems (Guilfoyle, 2003; Kleinman 1980; Lupton, 2012). Interventions that focus or act on the individual clinician, workplaces and structural supports, and broader institutions in relation to sexuality will therefore facilitate and support one another. These 'levels' are also not neatly separable. For example, improved professional education to increase mental health clinicians' knowledge, comfort, and competence also requires and represents a shift in institutional discourses related to sexuality and sexual health. The recommendations are expanded and discussed below.

There is a need to increase the quantity and quality of formal professional education (pre-registration and specialisation training) in relation to sexuality and sexual health for mental health clinicians. This is aligned with much of the existing research in the relevant literatures suggesting that clinicians need to be better educated in relation to sexuality and sexual health and supported to become more comfortable in raising sexuality within their clinical practice (e.g., Higgins et al., 2008; Hughes et al., 2018; Quinn et al., 2013b; White et al., 2019; Zatloff et al., 2020). There is some evidence that relevant formal education also functions to sensitise clinicians to the importance of sexuality within mental health settings (Quinn & Happell, 2012; Miller & Byer, 2012), indicating that increased formal education may also facilitate interest in relevant continuing professional education materials.

Importantly, there is also a need to consider more deeply *what* is being taught and how clinicians are learning to integrate – or exclude – aspects of sexuality within their clinical practice. As demonstrated in this thesis, inadequate sexuality-related care within mental health settings is not necessarily the result of an *absence* of relevant knowledge but, rather, the type and breadth of knowledge that clinicians have access to and consequently draw on in making sense of and responding to sexuality within their work. Accordingly,

sexuality-related education must not only become more available, it must be comprehensive and affirmative (i.e., expand beyond a focus on sex, bodies, and biology). Educators should strive to introduce students to broad conceptualisations of sexuality and sexual health, for example that include relationships, intimacy, and consent as well as risk and safety in relation to sexual expression or activity (e.g., Anandappa & Gad, 2013; Evans, 2011; Higgins et al., 2006c; Levine & Scott, 2010; McCann et al., 2019). This could include teaching students about the human rights implications of their practice regarding sexuality and sexual health. The analysis in Chapter Four demonstrated that some participants did already include broader and affirmative aspects in their conceptualisations of sexuality and sexual health, although other analyses suggested they did not regularly draw on or integrate these in their practice. This may represent an opportunity to build on clinicians' existing understandings about sexuality and sexual health in a way that supports them to better incorporate these conceptualisations into their clinical practice.

Students and clinicians should also be supported to critically reflect on their own understandings of sexuality and normative sex, relationships, and gender. Participants perceived sexuality to be taboo and difficult or inappropriate to discuss, especially within mental health settings, and some suggested that clinicians could develop more comfort by engaging in self-reflexivity about their own sexuality-related values and beliefs (Chapter Six). As demonstrated in Chapter Four, participants also drew on a range of pervasive cultural discourses of sexuality to talk about and make sense of sexuality and sexual health within the interviews. These discourses, which were not challenged by available institutional discourses (Chapter Seven), constructed normal or healthy sexuality within narrow and prescriptive boundaries that positioned heteronormative and monogamous sex as the most normal, natural, and healthy expression of sexuality (Barker et al., 2018; McPhillips et al.,

2001). In order to facilitate alternative possibilities for imagining, approaching, and responding to sexuality within mental health settings, clinicians need to be supported to identify and critique prevalent discourses that shape, and potentially limit, their own and their colleagues' current understandings and practice (Higgins et al. 2009; McCann, 2003, 2010). This can be facilitated within formal professional education, continuing professional education, and workplaces, and it can occur alone or in conversation with peers, colleagues, and supervisors.

Structural and procedural interventions within mental health settings are required to facilitate the translation of clinicians' sexuality-related knowledge and competence into clinical practice. Tools such as clinical interview guides or assessment sheets that include or prompt clinicians to raise sexuality within the therapeutic encounter could facilitate more regular and holistic integration of sexuality into everyday clinical practice. This has been suggested by participants in this research (Chapter Seven) and other studies (e.g., Hughes et al., 2018). Within inpatient settings, this might also involve reviewing or developing procedures that support clinicians and staff to maintain the safety of individuals in relation to sexual expression and relationships while also maintaining their autonomy and dignity to the highest level possible (Maylea, 2019; Ravenhill et al., 2020). More broadly, discussing and supporting individuals' sexuality, intimacy, and relationship needs must be valued within services by staff at all levels (i.e., become embedded in the workplace culture).

The integration and success of interventions described above must also be supported at the institutional level, for example by policy, professional standards, and practice guidelines representing broader institutional positions in relation to sexuality and sexual health within mental health settings and the mental health system. In Australia, the appointed

Chief of Psychiatry in each jurisdiction (state) is responsible for monitoring mental health care and can issue or revise standards for practice. The Chiefs of Psychiatry in some states have issued detailed guidelines for promoting sexual safety of consumers (e.g., NSW Ministry of Health, 2013) or are developing such guidelines (e.g., Chief Psychiatrist Western Australia, 2020). South Australia, where this project was conducted and where most participants worked, has no such guidelines. At the national level, mental health practice guidelines do acknowledge the need for mental health professionals and services to address sexuality, sexual health, and intimacy needs as part of holistic and person-centred care (e.g., Australian Government, 2013c). As discussed in the introduction (see section 1.3.2.), however, these documents do not offer detailed definitions of these terms or elaborate how these should be incorporated into clinical practice. This means that services and individual clinicians must draw their own conclusions about how to implement these guidelines, particularly in the absence of relevant state-level guidelines. The results of this thesis indicate that there may be wide variation in the interpretation of these guidelines, and that clinicians may interpret and approach sexuality and sexual health in a way that is limited and incomplete. There is therefore a need for additional clarity within available guidelines regarding what is meant by these terms and how these should be incorporated into clinical practice.

Beyond the sphere of direct clinical practice, I have also argued throughout this thesis that dominant pathologising and silencing discourses are reflected and reproduced by much of the research that purportedly aims to improve how sexuality and sexual health are addressed in mental health settings. This is because biology, bodies, and risk are still given disproportionate attention, effort, and funding within relevant research (see section 1.2.2.). Like in clinical practice, narrow conceptualisations of sexuality and sexual health shape

research, limiting the kinds of possibilities and interventions that can be imagined and developed to improve relevant clinical practice (Rohleder & Flowers, 2018). A broadened approach to sexuality is therefore needed within research as well as mental health settings. This requires engaging with and challenging dominant heteronormative, biomedical or reductionist, and neoliberal discourses of sexuality and health.

Research – or, knowledge production – is a part of the fabric of broader healthcare institutions (e.g., Lupton, 2012). Accordingly, the way that relevant research is conducted will be important in determining how successful interventions can be in facilitating sustained improvements in how sexuality, intimacy, and relationship needs are addressed within mental health settings. This will also determine whether any perceived 'improvements' are actually aligned with individuals' needs and desires and a recovery-oriented approach more broadly, or instead with the needs and desires of researchers, clinicians, and the broader institutional status quo. Researchers need to reflect on how they approach the topic(s) of sexuality, sexual health, intimacy, and relationships within the context of mental distress and mental health care. This can be achieved, in part, by reflexively considering how they ask questions, design research, interpret data, and who benefits from the knowledge produced; I modelled this in Chapters Two (section 2.6) and Three. Researchers also need to shift or expand their focus to explore broader and positive aspects of sexuality and sexual health including relationships, intimacy, identity, and pleasure. This would not only be aligned with the WHO (2006) working definitions that are regularly cited in relevant health and mental health literature, but with individuals' self-reported needs and desires for support in relation to sexuality and sexual health (e.g., McCann et al., 2019. Also see section 1.3.3.). Changes in how sexuality is approached within research will contribute to shifts in relevant institutional discourses.

Finally, and optimistically, broad changes in how sexuality is conceptualised and approached within mental health practice, services, and institutions (including research) will contribute to shifts in wider sociocultural understandings and assumptions about sexuality in the context of mental distress. This is because sociocultural discourses, institutional discourses, and clinicians' perceptions and practice choices in relation to sexuality and sexual health in the context of mental distress are mutually reinforcing (Burr, 2015a; Guilfoyle, 2003). This was demonstrated within this thesis, where participants drew on broad sociocultural discourses to make sense of sexuality and sexual health (Chapter Four), and these discourses were not challenged – indeed, were even reinforced – by the institutions where participants learned and worked (Chapter Seven). As discussed previously (section 1.2.3.), institutions including psychiatry and psychology have historically been involved in producing and reinforcing normative discourses of sexuality, including by identifying and defining non/normativity and ill/health in relation to gender, sexuality, and sexual expression (Barker et al., 2018; Foucault, 1980; Rubin, 1984; Sullivan, 2003; Weeks, 2010). Indeed, these institutions inhabit powerful positions in relation to authority over knowledge and their ability to contribute to the maintenance of, or shifts in, the social (and legal) status quo (Foucault, 1980; Lupton, 2012; Weedon, 1997). Accordingly, improved recognition within mental healthcare of individuals' sexual rights, needs, and desires will positively impact how individuals experiencing mental distress are perceived in the wider social imaginary as legitimate sexual beings and intimate or romantic partners.

A version of the four main recommendations produced as a result of this research and outlined above were communicated with participating clinicians via dissemination of the plain language summary of the project outcomes (discussed in section 2.6.2.2. and presented in Appendix J). I invited feedback on the summary and received several responses, with no

negative or challenging responses (though this does not mean that the project outcomes resonated with all participants). Some participants told me that they had used this summary to initiate conversations about sexuality and sexual health within their workplaces or had shared the documents with junior colleagues (personal communication, 2018). This signals the acceptability of these recommendations and potential interest or enthusiasm from clinicians toward efforts to support and improve their sexuality-related practice. More research is needed to this end. Considerations for future research in this area are discussed in the next section.

8.5 Limitations, and Directions for Future Research

Limitations in design and method have been discussed throughout the thesis, but some of these require further and focussed consideration here. These limitations and the opportunities for future research that they indicate, are discussed below.

It is important to acknowledge that people experiencing mental distress or illness were not invited to participate in this project, nor were any consumer advocates or leaders consulted or collaborated with during project design or implementation. This was a pragmatic choice based on the resources available to me[54]. To mitigate this absence, I actively grounded the project (including my interpretation of the data) in the perspectives of individuals who access mental health services as reported in Australian and international research that has directly explored their experiences and needs (see section 1.3). Despite this, excluding individuals who experience mental distress and illness means that their experiences have been constructed within this thesis by both participants within interviews and myself as researcher,

[54] When designing the project, I was still enrolled in the combined program (to complete a Master of Health Psychology concurrently) which created several limitations including in relation to anticipated time resources. I also did not have funding available to reimburse non-professional participants or consumer advocates with whom I might have consulted.

without the opportunity to construct themselves. In this way, individuals are a silenced, imagined Other within this thesis (discussed in detail in section 2.6.3.2.). This is juxtaposed against the broader intention of this study to contribute to improving individuals' experience of mental health care in relation to sexuality and sexual health needs. Research that attempts to make such an impact should be co-produced where possible (Happell et al., 2018. Also see Fine, 1994; Macleod et al., 2018; Marx & Treharne, 2018). Future research that explores sexuality and sexual health within (mental) health settings should collaborate with (paid) consumer leaders where appropriate and possible (Scholz et al., 2019b).

This research has the potential to contribute to the further psychiatrisation or medicalisation of sexuality. As discussed previously, knowledge produced through research can have negative or inequitable consequences for certain groups; even those it was intended to support or benefit in some way (see section 2.6.2.3.). The research presented here, as well as the wider literature to which it contributes, risks further medicalising sexuality by inviting the medical (and psychiatric) gaze deeper into the lives of people experiencing mental distress and illness (e.g., Mareck and Hare-Mustin, 2009). This is a particular concern when researchers speak or write *for*, rather than *with*, an oppressed Other through the research activities (Fine, 1994). Moreover, shifting the ways in which sexuality is approached within mental health settings or within the context of mental distress can only shift or expand, not extinguish, normative sex standards; and will therefore incite *transformed* regulatory and management procedures to ensure that these different or new standards are approximated as closely as possible (see Shildrick, 2009). Research about sexuality within mental health care is already established and ongoing, however, with or without my contribution. As I have argued, the existing conversation is dominated by approaches or perspectives that are directly pathologising and risk-oriented, and therefore reproduce discourses that limit the ability of

people experiencing mental distress or illness to experience and express sexuality, intimacy, and relationships as they would like (discussed in sections 1.3, 8.3). In contrast, the research presented in this thesis challenges and expands this existing literature by using a critical, social constructionist approach and amplifying individuals' needs as identified in consumer-based research. Nonetheless, the research presented here remains focussed on risk and silence too, even if it is via critique. Future research must also explore directly and ask questions about pleasure, intimacy, and wellbeing in relation to sexuality within the experience of mental distress and illness (Fahs & McClelland, 2016; Loeser et al., 2017; McCann et al., 2019), including in Australian contexts. This does not have to be specifically within the context of mental health settings; but it could inform research that does seek to understand and improve the ways in which individuals' sexuality, intimacy, and relationship needs are approached within mental health settings, in both clinical practice and research itself.

Another potential limitation or issue within this project is the centring of 'sexual health' within project materials and the research interviews. 'Sexual health' was the term used in the project title as it was presented in recruitment advertisements and participant information ('Sexual health in mental health settings': see Appendices A-C), though 'sexuality and sexual health' were consistently discussed within the bodies of those texts. Within interviews, conversations with participants often centred around the term 'sexual health', although we did discuss sexuality and I used probes to explore why or how participants included or excluded ideas, topics, or language from their understanding(s) of sexuality or sexual health more broadly. Nonetheless, some participants' specific and focussed understandings of sexual health may have shaped the data that we generated together by occluding potential discussions about the inclusion of broader aspects of sexuality within their practice (according to my interpretation). Indeed, in this thesis I have approached

sexual health as dependant on and related to a broad(er) conceptualisation of sexuality, but many participants did not share this conceptualisation (as evidenced in Chapter Four). While this is not an issue that can be entirely avoided within qualitative (or any) research, it does signify the importance of considering how the language used to recruit participants and frame conversations may shape the data generated, even before the data generation begins (also see Farvid, 2010).

The use of exploratory, participant-led in-depth interviews in this project was both a strength and a potential limitation, indicating opportunities for further research. Allowing the participants' talk to direct the interviews and indicate what topics were of importance or relevant to the conversation allowed me to explore participants' sense-making and as well as topics or ideas that I may not have thought to include in a more structured format such as semi-structured interview or survey (Braun & Clarke, 2013). This allowed me to examine closely participants' conceptualisations and perceptions of sexuality and sexual health in their work, in line with the main project aims. While this method allowed me examine how participants accounted for their (reported) practice and make sense of the phenomena of interest, relying on participants' accounts or reflections cannot provide an exhaustive or direct understanding of mental health clinicians' *practice* in relation to sexuality and sexual health within Australia. That is, I cannot make conclusive claims that participants do or do not practice in particular ways (nor perceive sexuality in particular ways: this relates to the limitation discussed immediately above). While the philosophical and theoretical frameworks grounding this project presume the absence of a final, discoverable truth (indeed, this was never a goal, see sections 2.2, 2.3), exploratory qualitative methods and in-depth interviews are not sufficient to exhaustively ask, or answer, important and useful questions about the ways in which sexuality-related needs are perceived and addressed within mental health

settings (e.g., Flowers & Rohleder, 2018). There will always be limits to what can be achieved, or produced, by a single research method or approach. Accordingly, there is a need for multiple theoretical and methodological approaches, and conversation between these, to 'broaden, challenge, question, and enhance' research about sexuality (see Tolman & Diamond, 2014), including within the context of mental distress and illness. Further research in relation to sexuality and sexual health in mental health settings should employ a range of methods and approaches including ethnography or participant observation, surveys, and Q-methodology as well as research grounded in specifically medico-scientific methodologies.

Future research will also need to include clinicians in other disciplines who serve key roles in mental health care in Australia (see Australian Institute of Health and Welfare, 2018; Australian Government, 2013). In particular, there is a need to explore GP perceptions of sexuality and sexual health, especially within the context of treating or responding to mental distress. GPs act as gatekeepers to some mental health services in Australia (Australian Institute of Health and Welfare, 2018), including those that are subsidised by government funding (e.g., Medicare rebated). They are also able to prescribe some psychotropic medications that have known sexual side-effects such as antidepressant medications (e.g., Basson & Gilks, 2018; Quinn et al., 2012). In the current study, participants often perceived GPs as well placed to identify and address some aspects of sexuality including safer sex practices, contraceptive choices, and sexual function (e.g., through the prescription of Sildenafil, commonly known as Viagra: see Chapters Four and Six). However, the broader literature indicates that medical practitioners, including GPs, may be similarly uncomfortable and unprepared to address sexual health concerns (e.g., Dyer & das Nair, 2013; Gott et al., 2004a). GPs may play an important role in addressing specific aspects of sexual health (i.e., primarily biological domains) but, like mental health professionals, they are expected to

provide person-centred care including in relation to mental health (Australian Commission on Safety and Quality in Health Care, 2011). They should therefore be able and prepared to address sexuality and sexual concerns beyond biologically based concerns where relevant (WHO, 2015), but it is not clear if they are equipped or supported to do so.

The novel finding that clinicians' conceptualisations of sexuality and sexual health vary within and across disciplines, reported in Chapter Four, has specific implications for future research in this area. Not only were participants' conceptualisations varied, but most participants' conceptualisations were not aligned with a broader approach to sexuality and sexual health outlined by the WHO (2006) or underpinning this thesis. Indeed, participants in this study talked about a broad range of topics in relation to sexuality and sexual health within the interview but, when asked directly, often drew much narrower boundaries between 'sexual health' and other aspects that I perceive as constituting 'sexuality' and that they had independently raised in the interview. This indicates a conceptual challenge for research in this area more broadly, particularly when using methods that are not qualitative and exploratory in nature (e.g., surveys): If sexuality and sexual health mean different things to different clinicians (even within a single profession), and if researchers and clinicians do not share an understanding of these terms, then researchers and participants may not be talking about the same things when asking and answering questions about these concepts and relevant clinical practice. Researchers might consider asking participants to clarify or explicate their understanding of sexuality or sexual health more often and explore what benefits these insights have for interpretation and knowledge production.

Overall, there is a need for ongoing research in order to better understand how to translate the results from research presented in this thesis and the wider literature into

relevant and appropriate interventions to improve the way that sexuality and sexual health are addressed within mental health settings. That research will need to take into account many of the critiques and limitations discussed above, and throughout this thesis more generally. In particular, future research must include efforts to understand individuals' own perceptions and experiences of sexuality and sexual health, and to identify if, where, and how clinicians' views and practice align (or could align) with individuals' needs. This can be achieved by centring the needs and perspectives of individuals experiencing distress and accessing mental health services within research and, wherever possible, designing research that meaningfully involves and engages these individuals.

8.6 Conclusion

Throughout this thesis, I have argued that the ways in which we – clinicians, educators, and researchers working together within institutions – conceptualise sexuality and sexual health and their (ir)relevance within the context of mental distress shapes how we *respond* to sexuality in mental health settings and how we are able to imagine, plan, and work towards a different future (Epstein & Mamo, 2017; Irwin, 1997; Kleinman, 1980; McCann et al., 2019; Rohleder & Flowers, 2018). I have demonstrated that reductionist understandings of sexuality and sexual health are dominant across mental health disciplines and settings in Australia, and how these may facilitate narrow and largely inadequate sexuality-related practice. Understanding how clinicians currently conceptualise sexuality and sexual health, as well as how they account for excluding or silencing these in their clinical practice, can assist researchers and educators in developing effective resources and interventions to improve clinicians sexuality-related knowledge, comfort, and competence. However, I also demonstrated how a narrow focus on individual clinicians to the exclusion of the wider institutional context is incomplete and fails to acknowledge the embeddedness of clinicians

within this context. Together, the analyses presented in this thesis indicate the need for *multilevel* foci and interventions to understand and improve how sexuality and sexual concerns are identified and addressed within mental health settings.

This is a fundamentally conceptual problem. In order to improve the way that individuals' sexuality-related needs are addressed within mental health settings and advance our understanding of the importance of sexuality, intimacy, and relationships for mental wellbeing, it is necessary to broaden the perspective in practice, education, and research away from a primary focus on sex and risk (McCann, 2003; Perry et al., 2018; Perry & Wright, 2006). This requires critically engaging with and challenging entrenched social norms that constrain efforts to take a more affirmative approach to sexuality, including dominant heteronormative, biomedical or reductionist, and neoliberal discourses of sexuality and health. Overall, we need to approach sexuality in a way that enables the development of truly recovery-oriented and person-centred mental health care which recognises and supports the enduring personhood and rights of individuals experiencing mental distress. Finally, and as I have argued throughout this thesis, in imaging and planning how sexuality and sexual health might be better understood and addressed within recovery-oriented mental health care, the perceptions, needs, and desires of individuals experiencing mental distress and accessing mental health services must be centred.

Appendices

Appendix A: Recruitment Advertisements

Advertisement posted on the Australian Psychology Society website (3 months, 2016).

Sexual health in mental healthcare

Are you a registered or endorsed psychologist?

Are you working with clients or patients in a metropolitan area in Australia?

You are invited to participate in a study exploring mental healthcare professionals' understanding and perceptions of sexuality and sexual health. Participants do not need any prior or specific experience in the area of sexual health.

This project aims to develop an in-depth understanding of the experiences and perceptions of sexuality and sexual health for three groups of professionals working in the mental health setting in Australia: psychologists, psychiatrists, and mental health nurses. Participants will be interviewed at a time that is convenient for them, either face-to-face or via skype or telephone. Interviews will take approximately 45-90 minutes.

This project is being conducted by Kristi Urry as part of her PhD project in the School of Psychology at the University of Adelaide and has been approved by the human ethics committee. Please email Kristi or Professor Anna Chur-Hansen for further information:

anna.churhansen@adelaide.edu.au

kristi.urry@adelaide.edu.au

Advertisement posted in the Australian College of Mental Health Nurses newsletter (*Tuesday Times*), March 2016.

Sexual health in mental healthcare

We are seeking mental health nurses to participate in a study exploring mental healthcare professionals' understanding and perceptions of sexuality and sexual health. Participants do not need any prior or specific experience in the area of sexual health.

This project aims to develop an in-depth understanding of the experiences and perceptions of sexuality and sexual health for three groups of professionals working in the mental health setting in metropolitan Australia: mental health nurses, psychologists, and psychiatrists. Participants will be interviewed at a time that is convenient for them, either face-to-face or via skype or telephone. Interviews will take approximately 45-90 minutes.

This project is being conducted by Kristi Urry as part of her PhD project in the School of Psychology at the University of Adelaide and has been approved by the human ethics committee. Please email Kristi or Professor Anna Chur-Hansen for further information:

kristi.urry@adelaide.edu.au

anna.churhansen@adelaide.edu.au

Advertisement posted on the *Psychology & Health Forum*, Marth 18th.

Are you a registered or endorsed psychologist?

Are you working with clients or patients in a metropolitan area in Australia?

I am currently seeking psychologists to participate in a study exploring mental healthcare professionals' understanding and perceptions of sexuality and sexual health. Participants do not need any prior or specific experience in the area of sexual health.

This project aims to develop an in-depth understanding of the experiences and perceptions of sexuality and sexual health for three groups of professionals working in mental health settings: psychologists, psychiatrists, and mental health nurses. Participants will be interviewed at a time that is convenient for them, either face-to-face or via skype or telephone. Interviews will take approximately 45-90 minutes.

I am conducting this project as part of my PhD project in the School of Psychology at the University of Adelaide. The project has been approved by the human ethics committee at the University.

Please send me an email if you are interested in participating or would like more information:

kristi.urry@adelaide.edu.au

Advertisement posted in the Central Adelaide Local health Network Mental Health newsletter, April 2016.

Opportunity to contribute

Mental health nurses, psychologists and psychiatrists are sought to participate in a research study to explore mental health care providers' experiences and perceptions of sexuality and sexual health. Please see attachment for more details. If you are interested, please contact Kristi Urry in School of Psychology, University of Adelaide (kristi.urry@adelaide.edu.au) for further details.

Email sent to psychiatrists in South Australia who completed training within the previous two years (aiming to recruit psychiatrists younger than 35), November 2016.

Kristi Urry, a PhD student in the School of Psychology at the University of Adelaide, is seeking consultant psychiatrists to participate in a study exploring mental healthcare professionals' understanding and perceptions of sexuality and sexual health. Interviews will take approximately 1-hour and participants do not need any prior or specific experience in the area of sexual health.

The research project, "sexual health in the mental health care setting", aims to develop an in-depth understanding of the experiences and perceptions of sexuality and sexual health for three groups of professionals working in the mental health setting in metropolitan Australia: mental health nurses, psychologists, and psychiatrists. The project is being supervised by Professor Anna Chur-Hansen (primary supervisor) and Dr Carole Khaw (co-supervisor).

More information about the project and contact details for Kristi, Anna and Carole can be found on the participant information sheet (attached).

Appendix B: Invitations to Participate Circulated by Supervisors

Invitation circulated by Anna Chur-Hansen.

Professor Chur-Hansen wrote formally and informally to colleagues in her professional network (psychologists and psychiatrists) via email and attached the participant information sheet presented in Appendix E.

Invitation circulated by Carole Khaw.

Dear

Thank you for considering this invitation to participate in the research project "Sexual health in the Mental Healthcare setting". This project is being conducted by Kristi Urry, a PhD student at the University of Adelaide. The research will form the basis for Kristi's PhD in the School of Psychology, under the supervision of Professor Anna Chur-Hansen (primary supervisor) and Dr Carole Khaw (co-supervisor).

Kristi is interested in health care professionals' understanding and perception of sexuality and sexual health. This project aims to develop an in-depth understanding of the experiences and perceptions of sexuality and sexual health for three groups of professionals working in the mental health setting in Australia: psychiatrists, mental health nurses, and psychologists. Participants do not have to have any prior or specific expertise in the area of sexual health; they must simply be working with clients or patients in a mental health setting.

Kristi would like to interview you about your experiences as a psychiatrist, at a time that is convenient for you. Interviews can be face-to-face or via telephone or skype and will take approximately 45-90 minutes. There are no immediate benefits for you. However, this research will advance our knowledge and understanding in this area that may have future benefits for health care providers, including yourself, and their clients.

Please see the attached information sheet for more details about the nature of the study and inclusion criteria. You can contact Kristi directly if you would like to participate, her contact details are included on the information sheet.

Thank you again for considering this invitation.

Yours truly

Dr. Carole Khaw

Appendix C: Participant Information Sheet

PARTICIPANT INFORMATION SHEET

PROJECT TITLE: Sexual health in the mental health care setting
STUDENT RESEARCHER: Kristi Urry
STUDENT'S DEGREE: PhD/Master of Psychology (Health)
PRINCIPAL INVESTIGATORS (supervisors): Professor Anna Chur-Hansen & Dr Carole Khaw

Purpose of the study
We are interested in health care professionals' understanding and perception of sexuality and sexual health. This project aims to develop an in-depth understanding of the experiences and perceptions of sexuality and sexual health for three groups of professionals working in the mental health setting in Australia: psychiatrists, mental health nurses, and psychologists.

Who can participate
Volunteers will be eligible to participate if they are:

- Psychiatrists – stage-3 registrars or Fellows of the College
- Specialist mental health nurses
- Registered psychologists – general or endorsed
- *And* currently working with patients or clients directly as part of your professional role
- *And* currently working at a metropolitan location area anywhere in Australia
- *And* fluent in English

Participants do not have to have any prior or specific expertise in the area of sexual health.

What happens during the study
Participants will be asked to talk about their experiences as a psychiatrist, mental health nurse or psychologist in a one-to-one, in-depth interview. This will include their experiences (if any) of clients' sexuality and sexual health. Participants can decline to answer questions that they feel uncomfortable discussing. Interviews will be audio-recorded and transcribed by the interviewer (KU). The transcripts will be anonymised (i.e., removing identifying information such as workplace and names) to maintain participants' confidentiality and anonymity. All participants will be given the opportunity to review and approve the final transcript from their own interview, and to receive a summary of the general research findings.

Location and duration
Interviews can be conducted face-to-face at the participant's workplace or at University of Adelaide North terrace Campus. A telephone or skype interview can be arranged for participants who are interstate or otherwise unable to meet with the researcher. Interviews will be scheduled at the participant's convenience and are expected to take between 45-90minutes. Participants will not be reimbursed for their time.

Safety and ethical issues
There are minimal risks of harm or distress to participants. To best ensure confidentiality and anonymity, the following measures will be taken: 1) pseudonyms will be used to tag transcripts; 2) potentially identifying information will be anonymised or excluded from the transcript; 3) participants will be given the opportunity to review and

approve their transcripts; 4) only the student researcher (KU) will know who has participated in the study. The supervisors will not know who participates, and they will only see de-identified transcripts.

Benefits of the study

There are no immediate benefits to participants. However, the research will advance our knowledge and understanding in this area and this may benefit health care providers and their clients and contribute to training.

Leaving the study

Participation in this project is completely voluntary. Participants can withdraw from the study at any time and for any reason prior to or during the interview. Participants can also withdraw after the interview and have their data retracted before the research is published.

Confidentiality, and data storage and use

Participants will not be identified in any reporting or publication of results. The research findings will be reported and made accessible in the following ways: 1) publication in relevant journals, 2) media release through the University following publication, 3) conference presentations/papers, 4) PhD thesis (KU).

All audio-recordings and transcripts will be stored on a secure, pass-word protected computer at the University that is accessible by Kristi only, and will be deleted from this computer at the end of the project. A copy of the final, de-identified transcripts will be stored securely on a USB in the School of Psychology for a period of seven years after completion of the project in accordance with the Australian Code for the Responsible Conduct of Research.

Complaint or concerns

The study has been approved by the Human Research Ethics Committee at the University of Adelaide (approval number 15/107). If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the supervisor (Anna Chur-Hansen: +61 8 3135 738, anna.churhansen@adelaide.edu.au). Contact Professor Paul Delfabbro (+61 8 3134 936, paul.delfabbro@adelaide.edu.au) or the Human Research Ethics Committee's Secretariat (+61 8 8313 6028, hrec@adelaide.edu.au) if you wish to speak with an independent person regarding concerns or a complaint, the University's policy on research involving human participants, or your rights as a participant. Any complaint or concern will be treated in confidence and fully investigated. You will be informed of the outcome.

Contact Information

If you are interested in participating in the study or have further questions about the nature of the research please contact Kristi Urry:

Email	**kristi.urry@adelaide.edu.au**
Call	[removed]

Appendix D: Consent Form

THE UNIVERSITY of ADELAIDE

Human Research Ethics Committee (HREC)

CONSENT FORM

1. I have read the attached Information Sheet and agree to take part in the following research project:

Title:	Sexual health in the mental health care setting
Ethics Approval Number: 15/107	This project has been approved through the University of Adelaide as low-risk research

2. I have had the project, so far as it affects me, fully explained to my satisfaction by the research worker. My consent is given freely.
3. Although I understand the purpose of the research project it has also been explained that involvement may not be of any benefit to me.
4. I have been informed that, while information gained during the study may be published, my information will be de-identified and anonymous.
5. I understand that I am free to withdraw from the project at any time.
6. I agree to the interview being audio-recorded. Yes ☐ No ☐
7. I would like to receive a copy of my de-identified transcript to review and approve Yes ☐ No ☐
8. I would like to receive a summary of the study findings Yes ☐ No ☐
9. I am aware that I should keep a copy of this Consent Form, when completed, and the attached Information Sheet.

Participant to complete:

Name: _____ Signature: _____ Date: _____

Researcher/Witness to complete:

I have described the nature of the research to _____
(print name of participant)

and in my opinion she/he understood the explanation.

Signature: _____ Position: _____ Date: _____

Appendix E: Independent Complaints Form

The University of Adelaide
Human Research Ethics Committee (HREC)

This document is for people who are participants in a research project.

CONTACTS FOR INFORMATION ON PROJECT AND INDEPENDENT COMPLAINTS PROCEDURE

The following study has been reviewed and approved by the University of Adelaide Human Research Ethics Committee:

Project Title:	Sexual health in the mental health care setting
Approval Number:	15/107

The Human Research Ethics Committee monitors all the research projects which it has approved. The committee considers it important that people participating in approved projects have an independent and confidential reporting mechanism which they can use if they have any worries or complaints about that research.

This research project will be conducted according to the NHMRC National Statement on Ethical Conduct in Human Research (see http://www.nhmrc.gov.au/publications/synopses/e72syn.htm)

1. If you have questions or problems associated with the practical aspects of your participation in the project, or wish to raise a concern or complaint about the project, then you should consult the project co-ordinator:

Name:	Anna Chur-Hansen, Professor
Phone:	[redacted]
Name:	Kristi Urry (PhD student)
Phone:	[redacted]

2. If you wish to discuss with an independent person matters related to:
   - making a complaint, or
   - raising concerns on the conduct of the project, or
   - the University policy on research involving human participants, or
   - your rights as a participant,

   Contact the Professor Paul Delfabbro on phone (08) 3134 936 or by email to paul.delfabbro@adelaide.edu.au or

   Human Research Ethics Committee's Secretariat on phone (08) 8313 6028 or by email to hrec@adelaide.edu.au

secretariat/ethics/human\complaints

Appendix F: Interview Guide

Note, interview guides were updated throughout data collection. The initial interview guide and final interview guide are presented below. Bolded questions indicate topics or questions that I made sure were discussed in every interview.

Initial interview guide.

- Age
- Location/country of training
    - How long ago in their mental health specialty especially
- Years of experience in mental health
- Where they work now
    - How long in that role
    - Full time or part time
    - SES – does it make a difference?
- Current work and work history
    - Typical day/consultation/appointment?
- Professional training
    - Training in sexuality or sexual health?
- Do they consider themselves equipped to deal with patients' sexual health needs?
- Asking about or discussing sexuality and sexual health – frequency?
- **What does sexual health (care) mean?**
- **Mental health/sexual health** – related?
- Do psychologists need to have sexual health knowledge and skills?
    - **Whose role is it?**
- Sex and sexual relationships on the ward – condoms, consenting, masturbation *[only if working in inpatient setting]*
- Ethical concerns when addressing sexual health
- Challenges or barriers to providing sexual health care
- Advantages to providing sexual health care
- Anything else?

Suggestions for other participants (Snowballing)

Final interview guide.

- Information sheet / Preamble / Consent form
- Profession
- Years of experience in mental health
- Current work
    - Length of time in current role
    - Full time / part time
    - Public / private
    - SES – does it make a difference?
- Location/country of training – how long ago?

- Current work – role, clients, experiences
- **What is mental health/illness?**
- **What is sexual health?**
    - How/when can people attain/achieve sexual health?
    - What does sexual health look like?
- Training → Where did they learn about SH?
- Mental health/sexual health – related?
    - SH issues as symptom of mental illness?
    - Symptom vs choice
    - Do their clients have sex?
- Clinician's personal values and attitudes towards sex/sexuality
- Does sexual health come up in their role?
    - Do they provide sexual health care? – What is it?
    - How do they incorporate SH into their practice?
    - Have they referred on because they couldn't provide care?
- Do psychologists need to have sexual health knowledge and skills?
    - **Whose role is it?**
- Typical [professional]?
- Ethical concerns / Challenges or barriers / Advantages
- **Why did they agree to participate in the study?**

Anything else to add?

- Age / gender identity / ethnicity / religion
- Questions or concerns?

Appendix G: Preamble

As I've outlined on the information sheet, I'd us to talk about your experiences as a psychiatrist and I'm particularly interested in hearing your experiences and understandings of sexual health and sexuality in your work. So I want to hear your stories and personal thoughts. There are no wrong or right answers – the approach that I'm taking in my research is one where you are the expert on your own experiences and understandings. Of course I have my own ideas about some of the things we'll talk about today, but I don't won't be positioning my ideas as "the right ones". Basically all I want to know is your views on my research topic.

Sometimes I might ask a question that is very broad, but that's to give you space to share whatever it is that you want to share about that topic or idea – I'll be trying my best not to lead you into talking about some things and avoiding others but of course you can choose not to talk about anything you like.

This is a qualitative study so all my data is being gathered from interviews with mental healthcare providers like yourself, and I'll be transcribing the interviews and then searching for patterns or themes in the textual data to develop answers to my research questions.

Do you have any questions?

Appendix H: Post-interview Summary Sheet

Date		Time began	
Day		Time ended	

Location	
Issues with location/ environment *(i.e., interruptions, noise, late etc)*	
Additional participant details	
Notes on interviewer/ interviewee interaction	
Topic guide – any problems?	
Interview – difficulties	
Interview – key points	
Themes emerging	
Analysis – did the interview seem to relate to other data in the study, to existing literature or theories?	

Appendix I: Published Manuscript: Supplemental Material, Chapter Five

Available at: https://journals.sagepub.com/doi/suppl/10.1177/1359105318790026

Supplemental material: Who decides when people can have sex? Australian mental health clinicians' perceptions of sexuality and autonomy

Kristi Urry & Anna Chur-Hansen

School of Psychology, University of Adelaide, Adelaide, Australia

Method: Data collection and analysis (extended)

In-depth interviews were conducted by the first author (KU) between January and December 2016 and lasted an average of 61 minutes (44–89 minutes). Eighteen interviews were conducted face-to-face at the participants' workplace or the authors' university and the rest were by telephone, depending on the participant's preference and location. Participants from all three professions were recruited and interviewed concomitantly. An interview guide was used to ensure that KU elicited participants' understanding of the terms 'sexuality' and 'sexual health', their experiences in addressing sexuality and sexual health in their work, and when and how this was considered relevant in their role(s). This guide served as an aide-memoire only, however, and interviews were generally directed by the participants and their experiences, using exhaustive probing to generate rich and detailed data. By the fourth interview, the authors had identified a pattern between participants' perceptions of sexuality and sexual health in their work and their conceptualisations of mental health and illness. Accordingly, the interview

guide was updated to additionally always elicit participants' understandings of mental health and illness.

Interviews were audio-recorded and transcribed verbatim by KU. Participants were given the option of receiving a copy of their de-identified transcript to review and approve, and most chose to do so. Two participants requested further de-identification and three provided clarifying remarks about elements of their transcript which were included as data in the analyses. KU kept an audit trail throughout the entire project and noted preliminary codes and patterns generated during data collection. These notes were used to update and modify the interview guide as required and to identify when saturation had been reached within each profession group, at which time interviewing ceased for that group. Data collection was considered 'complete' when the authors agreed that the data were saturated within and across profession groups. This judgement regarding saturation, or completion of data collection, was a pragmatic one that referred mainly to the semantic level of the data (i.e., no 'new' experiences were being discussed by participants and no new preliminary codes or patterns were being generated by the researchers). Moreover, this judgement was made on the provision that more data would be collected if, for example, this appeared necessary for theme development during data analysis; but this was not the case since the analysis was carried out across all three professional groups (i.e., with all twenty-two interviews) and no more data was collected.

The project was guided by a social constructionist epistemology, whereby meaning is understood as socially produced and language is active in this meaning-making process (Gergen, 2009). Consistent with this perspective, we applied a form of critical thematic analysis to the data following Braun and Clarke's (2006, 2013) iterative six-step process. We were most interested in identifying latent aspects of the data in relation to the research question. That is,

we were interested not only in what participants said but *how* and *why* they understood and made meaningful their experiences by drawing on particular ideas and conceptualisations. Initial coding and analysis stayed 'close' to the data and then preliminary themes that were relevant to the current research question became the analytic focus. The development of the final latent themes was necessarily interpretive and theoretical (see Braun & Clarke, 2006). The authors moved flexibly between a close reading and re-reading of the raw data, notes from data collection, codes, initial themes, and final latent themes throughout the analysis and particularly during development of the final themes. Coding and analysis was undertaken primarily by the first author (KU) with frequent discussions with the second author (ACH), and ACH independently reviewed the final themes against the raw data.

Reflexive statement

The authors are Australian woman of European decent. KU's academic training has been in the area of psychology but she is not a trained psychologist, while ACH is an endorsed health psychologist and academic. KU's lack of experience and shared understanding of working in a clinical setting was attended to during the research process through conversations with ACH to gain more insight into clinicians' experiences and to hear her (ACH's) reflections on the data.

Results (extended)

Here, we provide a deeper context for the three themes discussed in the main paper by giving an overview of participants' understanding of sexuality, sexual health, and mental health and illness. We also clarify our use of language (see the introduction in the results section of the main paper).

Participants' conceptualisations of sexuality and sexual health were varied but could be broadly categorised as "all about sex" [Jake, nurse] and "more than just having sex" [Yvonne, nurse]. All participants discussed biological and physical aspects of sexual health such as physical functioning, transmission of disease, and reproduction. Many participants also spoke about sexuality and sexual health as a part of general wellbeing and involving, for example, relationships, emotional safety, sexual identity, and intimacy that was not confined to genital stimulation or penetration. Many participants shifted between varying conceptualisations throughout their interviews depending on the context of the experiences they were discussing. What participants meant when they talked about 'sex' and sexual expression ranged from heterosexual penetrative sexual intercourse to other forms of sexual activity, expression, and intimacy including holding hands or having a cuddle. We use the term 'sex(uality)' to reflect this elastic understanding around what it means for an individual to act on or express their sexuality.

Similarly, there was no single agreed definition of mental health or illness within or across professions. Participants' conceptualisations ranged from predominantly biomedical or otherwise bound by diagnostic categories to broader concerns with "mental *health* [and …] mental health *issue[s]*" [Emily, nurse] without necessitating specific diagnoses. Regardless of the underlying framework, most participants' conceptualisations of psychological distress and illness drew broadly on notions of dysfunctionality. Mental health was described as the ability to self-regulate, think rationally, and function in a socially acceptable way. Mental illness was constructed in opposition to this, either actively or by omission, as a lack of self-regulation, rationality, and functionality in everyday life. There was a lack of concordance across the data for what it means to be (dys)functional but participants considered 'dysfunctionality' to be the

primary reason for most individuals' engagement with mental health services, both within and outside of specific diagnostic categories.

The problem of how to refer to psychological distress and illness is an ongoing conceptual challenge (also see Priebe, 2016). We refer to 'mental illness' throughout the paper in a way that reflects the participants' nebulous and largely varied conceptualisations of the experiences for which individuals are engaged in mental health services (i.e., rather than referring to a specific definition of mental illness). We also use the term 'mad/ness' to orient explicitly to the socially constructed nature of mental illness and the ambiguous categorisation of psychological distress and its many gradations. This is not to discount or challenge the real distress experienced by people who are engaged with mental health services and to whom psychiatric diagnostic categories are often applied. Rather, this challenges the biomedical paradigm that currently dominates (mental) health discourse and opens new possibilities for thinking about and responding to these experiences.

References

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101. doi:10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*: Sage.

Gergen, K. J. (2009). *An invitation to social construction* (second ed.). Los Angeles: SAGE.

Priebe, S. (2016). A social paradigm in psychiatry – themes and perspectives. *Epidemiology and Psychiatric Sciences, 25*(6), 521-527. doi:10.1017/S2045796016000147

Appendix J: Plain Language Summaries

Two plain language summaries are included below: A summary in brief, and the full-length summary.

Sexual health in the mental health setting

THE UNIVERSITY of ADELAIDE

Mental health care providers' understandings and perceptions

This summary presents the results from a PhD research project conducted by Kristi Urry in Australia from 2015 to 2019. The project involved interviewing psychologists, psychiatrists and mental health nurses who were working directly with individuals across a range of mental health settings in four Australian cities. The focus of the research was on developing a nuanced understanding of how the participating mental health care providers conceptualise sexuality and sexual health and how they perceive these as relevant to their professional roles.

The project was approved by the School of Psychology Human Research Ethics Subcommittee at the University of Adelaide (reference: 15/107). Results were generated using thematic analysis.

Results

- Participants' conceptualisations of sexuality and sexual health varied widely both across and within professions. Two overarching themes captured these conceptualisations:
  - *Sexual health is "all about sex":* Within this theme, sexual health meant that: Sex is biologically and physically safe; genitals 'function' in a normal way to achieve sex; and desire for sex is 'normal' (level and type of desire). This was the most common understanding of sexual health.
  - *Sexual health is "more than just having sex":* Many participants also included broader aspects in their understanding of sexual health that went beyond a focus on 'sex'. This Included intimacy, relationships, and emotional safety. How people feel about themselves in relation to their gender and sexuality identity, desires and expression was also important. This holistic understanding of sexual health was difficult for participants to define in a concrete way.
- 'Safe sex' was seen as one of the most important ways to be sexually healthy. Many participants were worried that people experiencing mental illness may not have the capacity to practice safe sex: Sexual expression was therefore seen as being especially risky in the context of mental illness.
- Most of the time, sexual health was seen as irrelevant or a low priority in the mental health setting. This produced a 'silence' around sexuality related issues which was maintained by individual providers and their practice choices, workplace policies, and broader institutional norms.

Implications

Participating psychologists, psychiatrists and mental health nurses did not have a shared understanding of sexuality and sexuality health (within or between professions). The results also indicate that sexuality and sexual health related issues were not addressed consistently in the mental health settings were the participants worked.

More research is needed to understand how the results from this and other studies can be translated into useful guidelines for professional mental health practice and education. More immediately, providers, educators, and researchers can:

- Reflect on their understandings, professional practice, and level of comfort in relation to sexuality and sexual health
- Reflect on their judgements and values in relation to sexual expression and how these might shape their professional practice (i.e., what 'counts' as safe, appropriate, and normal sexual expression?)
- Consider the opportunities in exploring broader and positive aspects of sexual health including relationships, intimacy, identity, and pleasure
- Consider whether the tools, policies and culture within workplaces support providers to identify and respond to service users' sexual health related needs (i.e., what changes can be made?)

Kristi Urry Carole Khaw & Anna Chur-Hansen | Contact: kristi.urry@adelaide.edu.au

This summary is based on a longer report: Urry, K., Khaw, C. & Chur-Hansen, A. (2018). *Sexual health in the mental health setting: A snapshot of mental health providers' understandings and perceptions*. Adelaide: University of Adelaide.

Sexual health in the mental health setting

A snapshot of mental health care providers' understandings and perceptions

Kristi Urry, Carole Khaw & Anna Chur-Hansen

2018

This report presents a summary of the results from a PhD research project conducted by Kristi Urry in Australia from 2015 to 2019. The project involved interviewing psychologists, psychiatrists, and mental health nurses who were working directly with individuals in Australian metropolitan mental health settings. The focus of the research was on developing a nuanced understanding of how mental health care providers conceptualise sexuality and sexual health and the relevance of this in their professional roles. This information is directed towards mental health care providers from all disciplines who are working with individuals who are experiencing psychological distress or mental illness and educators and researchers in the areas of mental and sexual health care.

Sexual health in the mental health setting: A summary

Introduction

This report summarises three studies from a PhD research project conducted by Kristi Urry between 2015 and 2019 at The University of Adelaide, Australia. The overall aim of this project was to develop an in-depth understanding of the perceptions and experiences of sexuality and sexual health for three groups of mental health care providers in Australia: psychologists, psychiatrists, and mental health nurses. We were particularly interested in considering: (1) How providers conceptualise sexuality and sexual health within the context of their work; (2) how providers perceive sexuality as being relevant in the context of mental health and illness; and (3) providers' experiences in encountering or addressing sexuality and sexual health related concerns in their work.

The report aims to provide an understanding of current practice regarding sexual health in mental health settings and to contribute to broader efforts to enhance mental health care and the valuable work undertaken by service providers. A holistic understanding of sexual health was applied in this project, where sexual health is defined as "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity" (World Health Organization (WHO), 2006). We are grateful to the mental health care providers who generously gave their time to participate in the project.

This report is organised into three main sections. This section introduces the project and briefly outlines who participated and what was involved. The second section provides a summary of the main results from the project and is divided into three sub-sections, each addressing a main research question. The final section provides an explanation of what these results tell us about current professional practice regarding sexuality and sexual health in mental health settings and provides suggestions for future directions in practice, education, and research. Further contact information and a list of outputs from the research, other than the PhD thesis, are provided at the end of the document.

Who participated and what was involved?

Eight psychologists, six psychiatrists, and eight mental health nurses participated in the project. Participants were working with a range of individuals (service users) and across various mental health settings including private practice, community mental health, emergency departments, and inpatient facilities in four Australian cities. The majority of participants were of European decent and all had completed their professional education and training in Australia or New Zealand. Participants ranged in age from 25–75 years, and in qualified professional experience from 2 months to 40 years.

In-depth, one-to-one interviews were conducted by Kristi between January and December 2016 and lasted an average of 61 minutes (44–89 minutes). The results were generated using thematic analysis; this is a qualitative method that allows the researcher to develop patterns within and across the data (anonymised interview transcripts) and generate themes in response to specific research questions. The interview transcripts were anonymised and all participant names appearing in this document are pseudonyms. The project was approved by the School of Psychology Human Research Ethics Subcommittee at the University of Adelaide (reference: 15/107).

Results

Overall, participants generally considered sexuality and sexual expression to be "a critical aspect of being alive" and "part of living a normal life". They also agreed that being sexually healthy is important for mental health. The way that participants understood and made sense of sexuality, sexual health, mental illness and mental health varied widely both within and across the three profession groups (psychology, psychiatry and mental health nursing). Participants' conceptualisations of sexuality and sexual health ranged from exclusively biomedical to very holistic. Conceptualisations of mental health and illness were similarly varied but broadly centred on the idea of (dys)functionality in everyday life.

A summary of the results generated for each of the three main research questions is provided below. Participants talked about a range of important issues and experiences regarding sexual health in the mental health setting. Some of these do not feature prominently in this summary, however, because they were only small sub-themes within broader overarching themes; these issues include iatrogenic sexual dysfunction, paraphilia, sexual assault and intimate partner violence. The quotes provided may not speak to all participants' understandings or experiences but they illustrate the presented themes that were developed through analyses using the entire dataset (i.e., the interview transcripts from all 22 participants across the three professions).

Study 1: How do participants understand sexuality and sexual health within the context of their work?

Participants' conceptualisations of sexuality and sexual health varied widely within and between the three profession groups. Two overarching themes were generated to describe and make sense of these understandings: sexual health as *"all about sex"* and *"more than just having sex"*. Most participants considered sexual health to be an important part of the human experience but this importance was understood in different ways depending on how sexual health was conceptualised more generally.

Sexual health is "all about sex"

Conceptualisations of sexual health that focussed on 'sex' tended to be biomedical, individualistic and risk-oriented. Within this conceptualisation, being sexually healthy meant that 'sex' was biologically and physically safe, that individuals' genitalia 'worked' to achieve climatic sexual intercourse, and that sexual desire was 'normal' in terms of level of libido and the types of sexual experiences desired. It was also important that people did not experience non-consensual, forced, or otherwise violent sexual intercourse.

> *"Sexual health, so straight up things like STDs [sexually transmitted diseases] and things related to that, or sexual function issues [so] people who have got significant issues with impotence or*

other sexual function issues. And side effects of medication obviously… us making things worse" (Eric, psychiatrist)

'Sex' mostly referred to penis-in-vagina intercourse between two cisgender adults of consenting and reproductive age. In this way, participants' ideas about sex and sexual health were often very heteronormative[1], though other forms of sexual behaviour or sex between people who are sexuality and gender diverse was discussed too. This sex-centred conceptualisation of sexual health was the most common and tended to be core to most participants' accounts, regardless of whether they also included more holistic aspects of sexuality and sexual health.

"My understanding is that anything to do with sex has got to do with sexual health and sexuality really, because… I mean sexuality is how somebody identifies or which sexual partners they like to choose, and then that also has an impact on their sexual health because [it impacts on] whether or not they're going to be safe or not safe, or engaging in risky behaviours because they've taken substances or because they've got a mood disorder. I think it all sort of ties in." (Jake, nurse)

Sexual health is "more than just having sex"

Many participants' conceptualised sexuality and sexual health in a way that included broader aspects that were about "more than just sex". This broader conceptualisation could include an acknowledgement of or emphasis on: the importance of intimacy and connection; relationships and broader interpersonal contexts in which sexual expression can occur; and emotional safety in addition to just 'consent' (i.e., physical safety). So, sexual health was understood as a sense of wellbeing that included the ideas described in the 'all about sex' theme, above, but also more.

"I guess for me it [sexual health] would really be about feeling comfortable and confident in yourself and your experience and what you want and what you get." (Gale, psychologist)

Participants often found it difficult to articulate the positive aspects that they considered to be a part of, and important for, sexual health within a holistic understanding. Moreover, sexual health was often understood as being 'different for everyone' and this contributed to the difficulty that participants had in defining what it meant to be sexually healthy.

> *"Well I guess [somebody who is sexually healthy is] comfortable with their sexuality and their sexual relationships, [that] that's a part of their life that's going well. Whatever form that takes." (Mia, psychiatrist)*

Sexuality was mostly seen as being related to or part of sexual health, especially when sexual health was understood in a holistic way, but this was not a unanimous conceptualisation. Some participants understood sexuality as a 'sense of self' that was broader than only sexual orientation or identity; that is, sexuality was how people felt about themselves in relation to their sexual identity, desires, preferences, and relationships.

Sexuality is an important part of being human

Most participants agreed that 'sexuality is an important part of being human' but this was perceived in different ways: Some participants oriented to the importance of sexual expression for expression's sake (i.e., the biologically-based need or desire for sexual intercourse), while others emphasised the importance of identity built and affirmed through (sexual) self-expression. Participants' perception of the importance of sexuality in general did not seem to determine the perceived importance of sexuality in the mental health setting specifically.

> *"Well I suppose I'm someone who thinks that health is a holistic thing and for most people sexual expression and sexual identity […] is a part of who we are as human beings. […] People feeling comfortable or satisfied around their sexual health or their sexual expression is also important and I just think if you try and deny any part of yourself it's not healthy. You know, it has impact." (Lucy, nurse)*

Sexual health, knowledge and culture

Participants' understandings of sexuality and sexual health can be understood as cultural knowledge: that is, as products of both profession-specific and broader cultural norms, values and ways of understanding (sexual) health and illness. These understandings were not strictly bound by profession but there was some patterned variation between groups that reflects differences in professional role and culture. Notably, psychiatrists tended to be the most biologically focussed and psychologists tended to be most focussed on psychological and social aspects of sexual health.

> *"I'm a doctor, I'm a psychiatrist, I tend to be focussed on the problem area" (Simone, psychiatrist)*

Conceptualisations of sexual health also varied greatly *within* profession groups. This was unsurprising since mental health care providers (especially psychologists) do not receive standardised or consistent education about sexuality and sexual health in tertiary or continuing professional development training (e.g., Hendry, Snowden & Brown, 2018; Levine & Scott, 2010; Miller & Byers, 2008, 2009). This means that providers' understanding of sexual health and what it means to be sexually healthy is also shaped by their broader cultural and social ideas, values, attitudes and experiences.

> *"[…] in terms of just atypical relationship structures so people co-parenting but not having a sexual relationship with each other, which I'm like 'that's cool' [okay] it sounds like a good way to raise kids, and that being quite judged by some clinicians. I think that some clinicians have a very fixed idea of how people's sexual behaviour should be. You know, man woman with only two people involved" (Fay, psychologist)*

Concluding remarks

Participants' conceptualisations of sexuality and sexual health were varied within and across the three professional groups but they tended to be centred on 'sex' and the biological and physical consequences or aspects of this. When sexual health was understood as predominantly biological it was often also

perceived as irrelevant in the *mental* health setting and as the responsibility of other health providers. For example, some participants suggested that medical doctors, particularly general practitioners, are best equipped to address sexual health concerns. Existing research indicates, however, that medical health care providers also often consider 'sexual health' to be outside of their role or professional capacities and are otherwise inconsistent in identifying and addressing sexual health concerns (e.g., Dyer & das Nair, 2013).

Broader psychological and social aspects of sexuality and sexual health often remained at the periphery of participants' conceptualisations, especially when they were discussing sexual health within the mental health setting specifically. For example, many nurse participants understood sexual health in a very holistic way but returned to a primarily biological understanding when they discussed sexual health directly within the context of their everyday work. This suggests that simply having a particular understanding of sexuality and sexual health does not always translate directly into professional practice. Other factors must also influence how sexual health is attended to within the mental health setting.

Study 2: How do participants understand sexuality and sexual health as being relevant, or not, in the context of mental health and illness?

Most participants considered sexuality to be important for wellbeing. Nevertheless, many participants often perceived sexuality and sexual health to be irrelevant or a low priority in the mental health setting. Sexuality was almost always considered to be relevant in the mental health setting when there was some form of perceived risk or danger associated with it. This danger was understood in two main ways, summarised below.

Sexual expression is risky

Most participants considered 'safe sex' to be a central part of a healthy sexual life. Sexual expression was understood as a potential risk or danger, usually in relation to sexually transmitted infections and

unplanned pregnancy. Being sexually healthy meant being responsible and reducing this risk by engaging in 'safe sex'; this meant having a good knowledge of the risks and responsibilities associated with sex and making 'good' choices to reduce these risks as much as possible, for example by using condoms to prevent transmission of disease and unplanned pregnancy[2].

> *"So I think if they [service users] want to be sexually healthy they're going to need to be comfortable in themselves [and] as long as they're sort of engaging in the right… As long as they're protecting themselves and not putting themselves or others at risk." (Brett, nurse)*

Some participants focussed on the potential risks of sexual expression specifically. They perceived service users as having the capacity to be responsible for themselves. So, these participants usually saw themselves as being able to provide education to service users that could support them to make good choices and engage in safe sex within the context of their mental distress or mental illness experience.

> *"So there's conversations around those issues that I have from time to time, about managing risks, regulating activity. Could they chose another [sexual] activity that wouldn't provide as much risk?" (Jeffrey, psychologist)*

Service users are sexually dangerous

Many participants understood mental illness to indicate a reduced capacity be responsible and make good choices. These participants often perceived service users as being unable to be responsible and to manage their sexual expression in a safe, 'healthy' way. So sexual expression was still associated with risk, but now the risk was 'located' within the service user rather than the sexual behaviour. Within this context, the provider's role was to make judgements about service users' sexual expression and manage this for them. For example, participants talked about the need to ensure that service users were protected from others who might try to have sex with them, as well as ensuring that they did not have sex with someone else (in an inpatient facility this included their partner who might be visiting them).

"I think that often if people have mental health issues where their abilities to organise or to function or their planning. So I'm talking here even about people who might be really highly anxious or who [are] moderately to severely depressed, where their frontal lobe might be affected and their ability to plan and organise is affected, then their ability to look after themselves [and] their sexual health [is affected and] they may not be… being as safe as they could be, they might be leaving themselves open to exploitation" (Sandy, nurse)

Sexual danger was usually gendered. Men were seen as being *a risk to others* through disease transmission and violence including sexual violence. Women were seen as being *at risk* of or vulnerable to (unplanned) pregnancy and sexual assault. In contrast, men were never talked about as being vulnerable to sexual violence because of mental illness. This pattern was consistent regardless of the participant's own gender.

"You also have predators on the ward […] People who, usually male, who will pursue… the female clients for sex. Trying to… get- do the act [sexual intercourse]. And of course if you've got someone who's quite vulnerable [then they're somebody] who's going to go and do it. So yeah [we have to] actually protect them." (Emily, nurse)

Participants who perceived service users as being sexually dangerous, or risky, were mostly those who worked in the context of 'serious mental illness' diagnoses; but this perceived risk was not restricted to periods of mania or psychosis (e.g., see Sandy's quote, above). Instead, these participants talked about the difficulty they faced in determining service users' capacity to be responsible, including in community settings (i.e., in settings where service users were not considered to be in crisis or require hospitalisation). Since they found it difficult to decide if a service user had the capacity to be responsible and make 'good' choices, the participants also found it challenging to explain when and why sexual expression might be risky and how that risk should be addressed.

"We do come across patients who […] may not have achieved optimum mental health and so sometimes their decision making may not be the wisest and so they may engage in behaviours

that may potentially put them at risk. So for example an obvious case is when some of our patients who do have severe mental illness [are] well enough to be in the community but will utilise sex to augment their income. And will do that in a way that is unfortunately associated with significant risk. […] So we would be very, very interested and concerned about that with some of our patients" (Ben, psychiatrist)

Concluding remarks

Participants' perceptions and judgements about sexual expression and risk were driven by an intention to act beneficently and provide best care. These judgements were, however, inconsistent across (and within) interviews and often relied on personal and social values about what kind of sexual expression is 'healthy' and when or where that expression should take place. For example, the sexual expressions and behaviours that were most often seen as being specifically risky and requiring management in the context of mental illness are also stigmatised in society more generally (e.g., condomless sex, casual sex, infidelity, non-monogamy, and sex work). So sexual choices that might be seen as 'poor' or 'bad' for people with no mental illness diagnosis were often perceived as being a symptom of mental illness or evidence of reduced capacity for decision making in people with mental illness diagnoses. In making these kinds of judgements, providers might therefore be reinforcing harmful cultural understandings of sexuality, choice and danger within the context of mental illness.

Study 3: What are participants' experiences in encountering or addressing sexuality and sexual health in the mental health setting?

When there was no perceived risk or danger, sexuality and sexual health were often considered to be irrelevant or be a lower priority than other, more important issues priority in mental health settings. This produced a 'silence' around sexuality and sexual health in the mental health setting. This silence was produced and maintained at the levels of both the individual mental health care providers (participants) and of workplaces and institutions.

Individual-level silence

Many participants considered sexuality and sexual health to be mostly irrelevant or not a high enough priority to be addressed within the mental health setting. This did depend on the context or the specific sexual health issue being discussed but the overall pattern was one of silence; the idea that sexual health did not need to be, or could not be, addressed in the mental health setting.

Many participants talked about sexuality as being "the most private thing" and therefore difficult or embarrassing to talk about, at least for service providers. Because of this, they often waited for the service provider to initiate conversations about sexual health concerns, to avoid embarrassing them. There was a common idea that if a service user did not raise any concerns then there was no sexual health issue. There has been plenty of research conducted with service users of health and mental health services that indicates that, precisely because they feel unsure and embarrassed, service users want their health care provider to initiate conversations about sexual health (e.g., Dyer & das Nair, 2013; Quinn & Browne, 2009). It seems likely that providers' reluctance to initiate these conversations is also driven, at least in part, by their own discomfort or avoidance of the topic.

> *"I also probably feel like I'm a bit unconfident in [talking about sexual health with service users…] I guess it's because it's not really a part of standard practice. And that there's quite a social stigma around talking about sex and sexuality. So I'd feel like I wouldn't be sure if the client wanted to go there." (Fay, psychologist)*

Silence was also evident in narrow understandings of sexual health. For example, some participants focussed on sex and sexually transmitted infections (which they understood as medical and therefore outside of their professional role) but never spoke about many other aspects of sexual health. This is problematic because providers cannot put into practice knowledge that they do not have.

Institutional-level silence

Workplace and institutional level factors constrained participants' practice regarding sexuality and sexual health. Many participants felt that their training at a pre-registration, tertiary level had been insufficient regarding sexuality and sexual health in the context of mental health and illness. For example, tertiary level education was discussed as being focussed only on medical aspects of sexual (and reproductive) health or as being very limited with regard to 'sex therapies'. Some participants also felt that opportunities for relevant continuing professional development (CPD) were lacking, or that there was not enough time to look for and complete relevant CPD opportunities.

> *"It's assumed that they [health professional students] just need a bit of basic knowledge [about sexual health] and it'll just be common sense. But it tends not to be." (Simone, psychiatrist)*

Some participants also talked about a lack of support from colleagues and senior management in their workplaces in relation to addressing sexuality and sexual health. For example, some participants explained that their occasional attempts to discuss service users' sexual health concerns at team meetings were met with disinterest.

Some workplace policies also directly constrained participants' ability to address sexual health concerns in their practice, such as rules that providers were "not supposed to ask directly" about service users' sexual orientation (Lucy, nurse). Similarly, some participants felt that there was a lack of tools or procedures to support them in asking about or addressing service users' sexual health.

> *"[We need more training] about how to approach [sexual health] with clients, making sure that it's covered in an assessment. I mean you certainly wouldn't find it on any mental health assessment sheet […] it looks like medical health but it doesn't talk about sexual health. So, having that included in that [assessment] as a prompt to remind [us] to ask about clients. [And training about] how to approach them, what are the things you need to approach with clients.*

If you have some basis around that… At least then as a as an experienced clinician you can kind of work out where it fits." (Yvonne, nurse)

Concluding remarks

Most participants considered sexuality and sexual health to be important for a person's overall wellbeing, including their physical and mental health. Despite this, many participants did not regularly incorporate or address sexual health in their practice or perceived sexual health as mostly separate from their everyday work. That is, sexual health related care was not embedded in many participants' practice. This silence was maintained at the levels of both individuals and workplaces or institutions.

These results suggest that efforts to improve sexuality and sexual health related care in mental health settings will not be successful if interventions focus only on providers at an individual level. For example, many education and communication based models aim to increase providers' knowledge or comfort in discussing sexual health with service users. If change does not also occur at the level of workplaces and institutions, including changes to workplace procedures and policy that currently constrain sexual health related practice, then interventions aimed at individual providers may not be maximally effective.

Implications and recommendations

This project aimed to explore how Australian mental health providers currently understand sexuality and sexual health and their experiences in addressing sexual health related needs in their work. This section outlines the take home messages from the project and makes suggestions for practice, education, and research regarding sexual health in mental health settings. These suggestions are based on the in-depth analyses of interviews with psychologists, psychiatrists, and mental health nurses conducted as part of this project and existing evidence from the relevant literature.

The results summarised in this report indicate that mental health care providers' understandings of sexuality and sexual health vary widely, both across and within disciplines. Their understandings of

why and when sexual health is relevant, or not, in the mental health setting was also inconsistent. This makes it difficult to research current practice regarding sexual health in mental health settings, for example because providers who participate in research might understand questions about 'sexual health' differently to each other and differently to the researcher, which means that everyone is not talking about the same thing. This may happen even if those providers (and the researcher) all belong to the same professional group or discipline.

- ➔ Service providers, educators and researchers can engage in reflection, either alone or with peers, to interrogate their understandings, professional practice, and level of comfort in relation to addressing sexuality and sexual health
- ➔ Researchers can consider how service providers who participate in research may have varied or inconsistent understandings of 'sexual health' and how this might impact or limit the scope of knowledge generated

The results also indicated a preoccupation with risk and danger regarding sexuality and sexual health in the mental health setting. This is not unreasonable since sexual expression can be associated with a range of dangers and harms that are biological, psychological, and social. However, a prevailing focus on risk in practice, research, and education comes at the expense of incorporating broader and positive aspects of sexuality and sexual health into current understanding and practice. It is these broader aspects of sexuality and sexual health that service users often identify as important to them and with which they would like support (e.g., Boucher et al., 2016; Deegan, 1999; McCann, 2010).

- ➔ Service providers, educators, and researchers might reflect on their own judgements and values regarding sexual expression and how these could shape their professional practice (i.e., what 'counts' as safe, appropriate, and normal sexual expression?)
- ➔ Service providers, educators, and researchers can consider how risk is given a disproportionate level of attention, effort, and funding and what opportunities could be gained by also exploring

broader and positive aspects of sexual health including relationships, intimacy, identity and pleasure

Identifying and managing (sexual) risk in the context of mental illness is a pertinent and, as many participants expressed, complex issue; but it is not the whole picture when it comes to sexual health and wellbeing. Current conceptualisations of best care in mental health settings call for holistic, person-centred and recovery-oriented care (National Practice Standards for the Mental Health Workforce, 2013). From a holistic perspective, sexual health is about much more than disease, pregnancy, and violence (e.g., WHO, 2006) but mental health care providers' current understandings of and practice regarding sexual health do not seem to reflect this. This problem does not reflect 'poor practice' by individual providers specifically; rather, this indicates a broader need to enhance relevant professional education and to develop tools, procedures, and workplace cultures that equip and support providers to identify and respond to service users' sexual health related needs.

- ➔ Service providers, educators, and researchers might consider whether the tools, policies and culture within workplaces support or constrain providers' ability to identify and address service users' sexual health related needs
- ➔ Educators and researchers should consider how providers' understandings and practice regarding sexuality and sexual health, including psychological and social aspects of this, can be better supported

Service providers, educators, and researchers strive to conceive, develop, and deliver best possible care but excluding sexuality and sexual health needs in the mental health settings is at odds with this goal. We are not suggesting that service users are never vulnerable or never require help to stay safe, including with regards to their sexual expression. We also acknowledge that sexuality cannot be addressed by all providers all the time. However, best care must include identifying and responding to sexuality and sexual health related needs when they arise (*National Practice Standards for the Mental*

Health Workforce 2013; WHO, 2006). This project has contributed to ongoing efforts to understand and improve sexual health related practice within the mental health setting.

We need more research

More research is needed that explores mental health care providers' current understandings and practice as well as their education needs regarding sexuality and sexual health. In particular, it would be very useful to develop a better understanding of how providers' personal understandings and experience of sexuality and sexual health impact or shape their professional practice in the mental health setting. This is especially important given the current scarcity of relevant and appropriate education at both tertiary and continuing professional development levels. If providers are not receiving training about sexual health during professional education then they must be drawing on knowledge gained elsewhere to make sense of questions of like 'what is sexual health' and to understand how best to respond when confronting issues of sexuality and sexual health in their work.

We also need more research to better understand how to translate the results from this study, and others like it, into relevant and appropriate education and practice guidelines for mental health providers. Best practice mental health services in Australia aim to be recovery-oriented and person-centred (*National Practice Standards for the Mental Health Workforce* 2013). Therefore, future research must also include efforts to understand service users' own perceptions and experiences of sexuality and sexual health, and to identify if and where providers' views align with service users' identified needs.

Notes.

[1] Heteronormativity is the assumption that everyone is heterosexual and, often, cisgender (i.e., their assigned sex at birth is congruent with their gender identity: Johnson, 2015)

[2] It was most common for participants to talk about 'safe sex' between a man and woman of consenting, reproductive age. Condoms are not the only way to practice safe sex, however, and they are not relevant, appropriate or useful for all types of sex or sex between all people.

About the researchers

Kristi Urry worked in collaboration with Professor Anna Chur-Hansen and Dr Carole Khaw. Anna is an academic based at the University of Adelaide and a practicing health psychologist. Carole is a sexual health physician who works in SA Health. Like Kristi, Anna and Carole are committed to improving health care in Australia, particularly with regard to sexual and mental health.

For further information, please contact:

Kristi Urry | *kristi.urry@adelaide.edu.au*

School of Psychology, Faulty of Health and Medical Sciences, University of Adelaide

Output from the project

Published, peer-reviewed articles:

Urry, K., & Chur-Hansen, A. (2018). Who decides when people can have sex? Mental health clinicians' perceptions of sexuality and autonomy. *Journal of health Psychology*. doi:10.1177/1359105318790026

Conference presentations:

Urry, K. (2018, September). "Some clinicians have a very fixed idea of how people's sexual behaviour should be": Mental health settings as heteronormative spaces. Presented at *5th Annual Gender, Sex and Sexualities Postgraduate and Early Career Researcher Conference, Adelaide, South Australia.*

Urry, K., Khaw, C., & Chur-Hansen, A. (2017, July). Who decides when people can have sex? Mental healthcare providers' perceptions of sexuality and autonomy. Presented at *10th Biennial International Society of Critical Health Psychology Conference*, Loughborough, England.

Urry, K. (2017, July). (Non)Disclosure of sexual identity in sexuality research: Reflexive account from a queer researcher. Presented at *Qualitative Methods in Psychology Conference*, Aberystwyth, England.

Conference posters:

Urry, K., Khaw, C., & Chur-Hansen, A. (August, 2016). "It's more than just sex isn't it…": Sexual health in the mental health setting. Poster presented at the *European Health Psychology Society and British Psychological Society Division of Health Psychology Conference*, Aberdeen, Scotland.

Urry, K., Khaw, C., & Chur-Hansen, A. (December, 2016). Healthcare providers' understanding of sexual health in the mental health setting. Poster presented at *International Congress of Behavioral Medicine*, Melbourne, Australia.

Other:

Urry, K. (2018, October 1). Everything sexy might be dangerous… but let's talk about intimacy, pleasure and relationships too [Web blog post]. Retrieved from https://ischp.info/2018/10/01/everything-sexy-might-be-dangerous-but-lets-talk-about-intimacy-pleasure-and-relationships-too/

Urry, K. (2016, October 16). Sexual health: Not a specialist area. Presented to *SA College of Health Psychologists' Annual General Meeting and Continuing Professional Development on Sexual Health, Adelaide*.

References

Boucher, M. E., Groleau, D., & Whitley, R. (2016). Recovery and severe mental illness: The role of romantic relationships, intimacy, and sexuality. *Psychiatric Rehabilitation Journal, 39*(2), 180-182. doi:10.1037/prj0000193

Deegan, P. E. (1999). *Human sexuality and mental illness: Consumer viewpoints and recovery principles*. In P. F. Buckley (Ed.), Sexuality and serious mental illness. Amsterdam: Harwood Academic Press.

Dyer, K., & das Nair, R. (2013). Why don't health care professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. *The Journal of Sexual Medicine, 10*(11), 2658-2670. doi:10.1111/j.1743-6109.2012.02856.xc

Hendry, A., Snowden, A., & Brown, M. (2017). When holistic care is not holistic enough: The role of sexual health in mental health settings. *Journal of Clinical Nursing*. doi:10.1111/jocn.14085

Johnson, K. (2015). *Gender and sexuality issues in health psychology: Challenges from feminist and LGBTQ perspectives*. In Critical health Psychology, second edition (Ch. 6, 108-124). Murray, M. (ed). Palgrave Macmillion: New York.

Levine, S. B., & Scott, D. L. (2010). Sexual education for psychiatric residents. *Academic Psychiatry*, 34(5), 349-352. doi:10.1176/appi.ap.34.5.349

McCann, E. (2010). Investigating mental health service user views regarding sexual and relationship issues. *Journal of psychiatric and mental health nursing, 17*(3), 251-259. doi:10.1111/j.1365-2850.2009.01509.x

Miller, S. A., & Byers, E. S. (2009). Psychologists' Continuing Education and Training in Sexuality. *Journal of Sex & Marital Therapy, 35*(3), 206-219. doi:10.1080/00926230802716336

National Practice Standards for the Mental Health Workforce. (2013). Melbourne, Victoria: Victorian Government Department of Health.

Quinn, C., & Browne, G. (2009). Sexuality of people living with a mental illness: a collaborative challenge for mental health nurses. *International Journal of Mental Health Nursing, 18*(3), 195-203. doi:10.1111/j.1447-0349.2009.00598.x

World Health Organization. (2006). *Defining sexual health: report of a technical consultation on sexual health*, 28-31 January 2002, Geneva. WHO.

Suggestion for reference:

Urry, K., Khaw, C., & Chur-Hansen, A. (2018). *Sexual health in the mental health setting: A snapshot of mental health providers' understandings and perceptions*. Adelaide: University of Adelaide.

References

Aguinaldo, J. P. (2012). Qualitative analysis in gay men's health research: Comparing thematic, critical discourse, and conversation analysis. *Journal of Homosexuality, 59*(6), 765-787. doi:10.1080/00918369.2012.694753

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Publishing: Arlington.

Anandappa, C. E., & Gad, H. (2013). Know your BIOTEACHERS when you assess sexual health. *Current Psychiatry, 12*(11), 39-40. Retrieved from https://go-gale-com.proxy.library.adelaide.edu.au/ps/i.do?id=GALE%7CA350338287&v=2.1&u=adelaide&it=r&p=AONE&sw=w

Anderson, R. M. (2013). Positive sexuality and its impact on overall well-being. *Bundesgesundheitsblatt-Gesundheitsforschung-Gesundheitsschutz, 56*(2), 208-214. doi:10.1007/s00103-012-1607-z

Annon, J. S. (1976). The PLISSIT model: A proposed conceptual scheme for the behavioral treatment of sexual problems. *Journal of Sex Education and Therapy, 2*(1), 1-15. doi:10.1080/01614576.1976.11074483

Anthony, W. A. (1993). Recovery from mental illness: The guiding vision of the mental health service system in the 1990s. *Psychosocial Rehabilitation Journal, 16*(4), 11. doi:10.1037/h0095655

Astbury-Ward, E. (2011). A questionnaire survey of the provision of training in human sexuality in schools of nursing in the UK. *Sexual and Relationship Therapy, 26*(3), 254-270. doi:10.1080/14681994.2011.618180

Attalah, S., Johnson-Agbakwu, C., Rosenbaum, T., Abdo, C., Byers, E. S., Graham, C., . . . Brotto, L. (2016). Ethical and Sociocultural Aspects of Sexual Function and Dysfunction in Both Sexes. *The Journal of Sexual Medicine, 13*(4), 591-606. doi:10.1016/j.jsxm.2016.01.021

Australian College of Mental Health Nurses. (2015). *Mental health nursing education: Position statement*. Retrieved from http://www.acmhn.org/images/stories/ENDORSED_Position_Statement_-_Education_for_specialist_mental_health_nurses_Dec_2015.pdf

Australian Commission on Safety and Quality in Health Care (2011). *Patient-centred care: Improving quality and safety through partnerships with patients and consumers*. ACSQHC, Sydney. Retrieved from https://www.safetyandquality.gov.au/sites/default/files/migrated/PCC_Paper_August.pdf

Australian Government. (2013a). *A National framework for recovery-oriented mental health services: Guide for practitioners and providers*. Melbourne, Australia: Victorian Government, Department of Health. Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovgde

Australian Government. (2013b). *A National framework for recovery-oriented mental health services: Policy and theory*. Melbourne, Australia: Victorian Government, Department of Health. Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-recovpol

Australian Government. (2013c). *National practice standards for the mental Health workforce 2013*. Melbourne, Australia: Victorian Government, Department of Health.

Retrieved from https://www1.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-n-wkstd13

Australian Institute of Health and Welfare. (2018). *Mental health services—in brief 2018*. Canberra, Australia: AIHW. Retrieved from https://www.aihw.gov.au/reports/mental-health-services/mental-health-services-in-australia-in-brief-2018/contents/table-of-contents

Australian Psychological Society. (2020a). Clinical psychologists. Retrieved from https://www.psychology.org.au/for-the-public/about-psychology/types-of-psychologists/Clinical-psychologists

Australian Psychological Society. (2020b). Psychologists with an area of practice endorsement. https://www.psychology.org.au/for-the-public/about-psychology/types-of-psychologists/Psychologists-with-an-Area-of-Practice-Endorsement

Baker, A. E., & Procter, N. G. (2015). 'You just lose the people you know': Relationship loss and mental illness. *Archives of Psychiatric Nursing, 29*(2), 96-101. doi:10.1016/j.apnu.2014.11.007

Barker, M. (2006). Sexual self-disclosure and outness in academia and the clinic. *Lesbian and Gay Psychology Review, 7*(3), 292-296. Retrieved from oro.open.ac.uk/17258/2/9CF739F1.pdf

Barker, M. J., Gill, R., & Harvey, L. (2018). *Mediated intimacy: Sex advice in media culture*. Polity Press.

Barker, P. (2003). The Tidal Model: Psychiatric colonization, recovery and the paradigm shift in mental health care. *International Journal of Mental Health Nursing*, *12*(2), 96-102. doi:10.1046/j.1440-0979.2003.00275.x

Barker, P., & Buchanan-Barker, P. (2011). Myth of mental health nursing and the challenge of recovery. *International Journal of Mental Health Nursing*, *20*(5), 337-344. doi:10.1111/j.1447-0349.2010.00734.x

Basson, R., & Gilks, T. (2018). Women's sexual dysfunction associated with psychiatric disorders and their treatment. *Women's Health, 14*. doi:10.1177/1745506518762664

Bladon, H. (2017). Out of the shadows: De-medicalising mental health nursing. *Mental Health Practice*, *20*(9). doi:10.7748/mhp.2017.e1187

Blalock, K. M., & Wood, S. K. (2015). Women living with serious mental illness: The impact of sexual stigma and sexual wellness on quality of life. *Women & Therapy, 38*(1-2), 77-88. doi:10.1080/02703149.2014.978218

Blondeel, K., De Vasconcelos, S., García-Moreno, C., Stephenson, R., Temmerman, M., & Toskin, I. (2018). Violence motivated by perception of sexual orientation and gender identity: A systematic review. *Bulletin of the World Health Organization*, 96(1), 29. doi:10.2471/BLT.17.197251

Bloor, G., & Dawson, P. (1994). Understanding professional culture in organizational context. *Organization Studies*, *15*(2), 275-295. doi:10.1177/017084069401500205

Boucher, M. E., Groleau, D., & Whitley, R. (2016). Recovery and severe mental illness: The role of romantic relationships, intimacy, and sexuality. *Psychiatric Rehabilitation Journal, 39*(2), 180-182. doi:10.1037/prj0000193

Braun, V. (2000). Heterosexism in focus group research: Collusion and challenge. *Feminism & Psychology, 10*(1), 133–140. doi:10.1177/0959353500010001015

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77-101. doi:10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. SAGE.

Braun, V., & Clarke, V. (2016). (Mis)conceptualising themes, thematic analysis, and other problems with Fugard and Potts' (2015) sample-size tool for thematic analysis. *International Journal of Social Research Methodology, 19*(6), 739-743. doi:10.1080/13645579.2016.1195588

Brinkmann, S., & Kvale, S. (2017). Ethics in qualitative psychological research. In C. Willig & W. S. Rogers (Eds.), *The SAGE handbook of qualitative research in Psychology* (2nd ed., pp. 259-273). London: SAGE.

Brown, H. K., Dennis, C. L., Kurdyak, P., & Vigod, S. N. (2019). A population-based study of the frequency and predictors of induced abortion among women with schizophrenia. *The British Journal of Psychiatry*, *215*(6), 736-743. doi:10.1192/bjp.2018.262

Brown, S. D., Reavey, P., Kanyeredzi, A., & Batty, R. (2014). Transformations of self and sexuality: psychologically modified experiences in the context of forensic mental health. *Health*, *18*(3), 240-260. doi:10.1177/1363459313497606

Buchanan-Barker, P., & Barker, P. J. (2008). The Tidal Commitments: Extending the value base of mental health recovery. *Journal of Psychiatric and Mental Health Nursing*, *15*(2), 93-100. doi:10.1111/j.1365-2850.2007.01209.x

Burgess, R. G. (2002). *In the field: An introduction to field research*. Routledge.

Burr, V. (2015a). *Social constructionism* (3rd edition). UK: Routledge.

Burr, V. (2015b). Social constructionism. In J. D. Wright (Ed.), *International encyclopedia of the social & behavioral sciences* (2nd ed., pp. 222-227). Oxford: Elsevier.

Byers, E. S. (2011). Beyond *The birds and the bees* and *Was it good for you?*: Thirty years of research on sexual communication. *Canadian Psychology, 52*(1), 20-28. doi:10.1037/a0022048

Chamberlain, K. (2000). Methodolatry and Qualitative Health Research. *Journal of Health Psychology, 5*(3), 285-296. doi:10.1177/135910530000500306

Chamberlain, K. (2015). Reflexivity: Fostering research quality, ethicality, criticality and creativity. In M. Murray (Ed.), *Critical health psychology* (2ne ed., pp. 165-181). Palgrave Macmillan.

Chamberlain, K., & Murray, M. (2009). Critical health psychology. In D. Fox, I. Prilleltensky, & S. Austin (Eds.), *Critical psychology: An introduction* (2nd ed., pp. 144-158). London: SAGE.

Chandiramani, R. (2010). Bodies and beyond: Where sexual health meets sexual rights. In A. Aggleton & R. parker (Eds.), *Routledge handbook of sexuality, health and rights* (pp. 351-358). Routledge.

Chief Psychiatrist Western Australia. (2020). Chief psychiatrist's sexual safety guidelines: Draft for consultation. Retrieved from https://www.chiefpsychiatrist.wa.gov.au/chief-psychiatrists-sexual-safety-guidelines-draft-for-consultation/

Clarke, V., Braun, V., Terry, G., & Hayfield, N. (2019). Thematic analysis. In P. Liamputtong (Ed.), *Handbook of research methods in health and social sciences* (pp. 843-860). Singapore: Springer.

Clouder, L. (2003). Becoming professional: exploring the complexities of professional socialization in health and social care. *Learning in Health and Social Care, 2*(4), 213-222. doi:10.1046/j.1473-6861.2003.00052.x

Conrad, P., & Bergey, M. (2015). Medicalization: Sociological and anthropological perspectives. In J. D. Wright (Ed.), *International encyclopedia of the social & behavioral sciences* (2nd ed., pp. 105-109). Oxford: Elsevier.

Cook, J. A. (2000). Sexuality and people with psychiatric disabilities. *Sexuality and Disability, 18*(3), 195-206. doi:10.1023/A:1026469832339

Corbett, R., Elsom, S., Sands, N., & Prematunga, R. (2017). An exploratory investigation of sexual health screening in the first 12 weeks of case management in populations with severe mental illness. *International Journal of Mental Health Nursing, 26*(2), 160-169. doi:10.1111/inm.12257

Corrêa, S., & Petchesky, R. (2007). Reproductive and sexual rights: A feminist perspective. In R. parker & P. Aggleton (Eds.), *Culture, society and sexuality* (2nd ed. pp. 314-332). Routledge.

Cort, E. M., Attenborough, J., & Watson, J. P. (2001). An initial exploration of community mental health nurses' attitudes to and experience of sexuality-related issues in their work with people experiencing mental health problems. *Journal of Psychiatric and Mental Health Nursing, 8*, 489-499. doi:10.1046/j.1351-0126.2001.00425.x

Crawford, R. (2006). Health as a meaningful social practice. *Health, 10*(4), 401-420. doi:10.1177/1363459306067310

Cromby, J., Harper, D., & Reavey, P. (2013). *Psychology, mental health and distress*. Macmillan International Higher Education.

Crossley, M. (2008). Critical health psychology: Developing and refining the approach. *Social and Personality Psychology Compass, 2*(1), 21-33. doi:10.1111/j.1751-9004.2007.00041.x

Davison, J., & Huntington, A. (2010). "Out of sight": Sexuality and women with enduring mental illness. *International Journal of Mental Health Nursing, 19*(4), 240-249. doi:10.1111/j.1447-0349.2010.00676.x

de Jager, J., & McCann, E. (2017). Psychosis as a barrier to the expression of sexuality and intimacy: an environmental risk? *Schizophrenia Bulletin*, 43(2), 236-239. doi:10.1093/schbul/sbw172

de Jager, J., Cirakoglu, B., Nugter, A., & van Os, J. (2017). Intimacy and its barriers: A qualitative exploration of intimacy and related struggles among people diagnosed with psychosis. *Psychosis, 9*(4), 301-309. doi:10.1080/17522439.2017.1330895

Deegan, P. E. (1999). Human sexuality and mental illness: Consumer viewpoints and recovery principles. In P. F. Buckley (Ed.), *Sexuality and serious mental illness* (pp. 21-33). Amsterdam: Harwood Academic Press.

Dein, K. E., Williams, P. S., Volkonskaia, I., Kanyeredzi, A., Reavey, P., & Leavey, G. (2016). Examining professionals' perspectives on sexuality for service users of a forensic

psychiatry unit. *International Journal of Law And Psychiatry, 44*, 15-23. doi:10.1016/j.ijlp.2015.08.027

DelGreco, M., & Christensen, J. (2019). Effects of Street Harassment on Anxiety, Depression, and Sleep Quality of College Women. *Sex Roles*, 1-9. Retrieved from https://link.springer.com/article/10.1007/s11199-019-01064-6

Department of Planning, Transport and Infrastructure. (2015). South Australia's land supply and planning system. Retrieved from https://www.sa.gov.au/topics/housing-property-and-land/building-and-development/land-supply-and-planning-system/south-australian-government-regions

Dorsay, J. P., & Forchuk, C. (1994). Assessment of the sexuality needs of individuals with psychiatric disability. *Journal of Psychiatric and Mental Health Nursing*, *1*(2), 93-97. doi:10.1111/j.1365-2850.1994.tb00025.x

Douglas, M. (1966). *Purity and Danger: An analysis of the concepts of pollution and taboo*. New York, NY: Routedge.

Dyer, K., & das Nair, R. (2013). Why don't healthcare professionals talk about sex? A systematic review of recent qualitative studies conducted in the United Kingdom. *The Journal of Sexual Medicine*, 10(11), 2658-2670. doi:10.1111/j.1743-6109.2012.02856.x

East, L., & Hutchinson, M. (2013). Moving beyond the therapeutic relationship: a selective review of intimacy in the sexual health encounter in nursing practice. *Journal of Clinical Nursing*, *22*(23/24), 3568-3576. doi:10.1111/jocn.12247

Edwards, W. M., & Coleman, E. (2004). Defining sexual health: A descriptive overview. *Archives of Sexual Behavior, 33*(3), 189-195. doi:10.1023/B:ASEB.0000026619.95734.d5

Eklund, M., & Östman, M. (2010). Belonging and doing: Important factors for satisfaction with sexual relations as perceived by people with persistent mental illness. *International Journal of Social Psychiatry, 56*(4), 336-347. doi:10.1177/0020764008101635

Elkington, K. S., Hackler, D., Walsh, T. A., Latack, J. A., McKinnon, K., Borges, C., ... & Wainberg, M. L. (2013). Perceived mental illness stigma, intimate relationships, and sexual risk behavior in youth with mental illness. *Journal of Adolescent Research, 28*(3), 378-404. doi:10.1177/0743558412467686

Ellingson, L. L. (2011). Analysis and representation across the continuum. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (4th ed., pp. 595-610). Thousand Oaks, CA: SAGE.

Ellis, J., Boger, E., Latter, S., Kennedy, A., Jones, F., Foster, C., & Demain, S. (2017). Conceptualisation of the 'good' self-manager: A qualitative investigation of stakeholder views on the self-management of long-term health conditions. *Social Science & Medicine, 176*, 25-33. doi:10.1016/j.socscimed.2017.01.018

Emmerich, N. (2015). Bourdieu's collective enterprise of inculcation: The moral socialisation and ethical enculturation of medical students. *British Journal of Sociology of Education, 36*(7), 1054-1072. doi:10.1080/01425692.2014.886939

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science, 196*(4286), 129-136. doi:10.1126/science.847460

Epstein, S., & Mamo, L. (2017). The proliferation of sexual health: Diverse social problems and the legitimation of sexuality. *Social Science & Medicine, 188*, 176-190. doi:https://doi.org/10.1016/j.socscimed.2017.06.033

Evans, D. T. (2011). *Sexual health matters! Learning for life: Mapping client need and professional sexual health education for nurses in England* (Doctoral thesis, University of Greenwich, London). Retrieved from https://gala.gre.ac.uk/id/eprint/8071/

Evans, D. T. (2013). Promoting sexual health and wellbeing: The role of the nurse. *Nursing Standard*, *28*(10), 53-57. Retrieved from https://www.researchgate.net/profile/David_Evans7/publication/259688352_Promoting_sexual_health_and_well-being_the_role_of_the_nurse/links/00b4952d558a505251000000.pdf

Fagin, L., & Garelick, A. (2018). The doctor–nurse relationship. *Advances in Psychiatric Treatment*, *10*(4), 277-286. doi:10.1192/apt.10.4.277

Fahs, B., & McClelland, S. I. (2016). When sex and power collide: An argument for critical sexuality studies. *The Journal of Sex Research*, *53*(4-5), 392-416. doi:10.1080/00224499.2016.1152454

Farvid, P. (2010). The benefits of ambiguity: Methodological insights from researching 'heterosexual casual sex'. *Feminism & Psychology*, *20*(2), 232-237. doi:10.1177/0959353509359136

Fileborn, B., & Vera-Gray, F. (2017). "I want to be able to walk the street without fear": Transforming justice for street harassment. *Feminist Legal Studies*, 25(2), 203-227. doi:10.1007/s10691-017-9350-3

Fine, M. (1994). Working the hyphens: Reinventing self and other in qualitative research. In N. Denzin & Y. Lincoln (Eds.), *Handbook of qualitative research* (pp. 70-82). Thousand Oaks, CA: Sage.

Finlay, L. (2002). Negotiating the swamp: The opportunity and challenge of reflexivity in research practice. *Qualitative Research, 2*(2), 209-230. doi:10.1177/146879410200200205

Flowers, P., Hart, G., & Marriott, C. (1999). Constructing sexual health: Gay men and 'risk' in the context of a public sex environment. *Journal of Health Psychology, 4*(4), 483-495. doi:10.1177/135910539900400403

Foucault, M. (1980). *The history of sexuality* (Vol. 1). London: Allen Lane.

Foucault, M., Baudot, A., & Couchman, J. (1978). About the concept of the "dangerous individual" in 19th-century legal psychiatry. *International Journal of Law and Psychiatry, 1*(1), 1-18. doi:10.1016/0160-2527(78)90020-1

Fox, D., Prilleltensky, I., & Austin, S. (2009). Critical psychology for social justice: Concerns and dilemmas. In D. Fox, I. Prilleltensky, & S. Austin (Eds.), *Critical psychology: An introduction* (2nd ed., pp. 3-19). London: SAGE.

Frost, N. A., & Nolas, S-M. (2011). Exploring and expanding on pluralism in qualitative research in psychology. *Qualitative Research in Psychology, 8*(2), 115-119. doi:10.1080/14780887.2011.572728

Fuller, J. (2017). The new medical model: A renewed challenge for biomedicine. *Canadian Medical Association Journal, 189*(17), E640-E641. Retrieved from https://doi.org/10.1503/cmaj.160627

Gaffney, A. (2015). The neoliberal turn in American healthcare. *International Journal of Health Services, 45*(1), 33–52. doi:10.2190/HS.45.1.d

Galbally, M., Snellen, M., & Lewis, A. J. (2011). A review of the use of psychotropic medication in pregnancy. *Current Opinion in Obstetrics and Gynecology, 23*(6), 408-414. doi:10.1097/GCO.0b013e32834b92f3

Gascoyne, S., Hughes, E., McCann, E., & Quinn, C. (2016). The sexual health and relationship needs of people with severe mental illness. *Journal of Psychiatric and Mental Health Nursing, 23*(5), 338-343. doi:10.1111/jpm.12317

Gergen, M. (2017). Qualitative methods in feminist psychology. In C. Willig & W. S. Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (2nd ed., pp. 289-305). London: SAGE.

Giami, A. (2002). Sexual health: The emergence, development, and diversity of a concept. *Annual Review of Sex Research, 13*, 1-35. doi:10.1080/10532528.2002.10559801

Goodwin, D. (2006). Ethical issues. In N. Mays & C. Pope (Eds.), *Qualitative research in health care* (3rd ed., pp. 53-62). Carlton, Victoria: Blackwell.

Gott, M., Galena, E., Hinchliff, S., & Elford, H. (2004a). "Opening a can of worms": GP and practice nurse barriers to talking about sexual health in primary care. *Family Practice, 21*(5), 528-536. doi:10.1093/fampra/cmh509

Gott, M., Hinchliff, S., & Galena, E. (2004b). General practitioner attitudes to discussing sexual health issues with older people. *Social Science & Medicine, 58*(11), 2093-2103. doi:10.1016/j.socscimed.2003.08.025

Granek, L., Danan, D., Bersudsky, Y., & Osher, Y. (2016). Living with bipolar disorder: The impact on patients, spouses, and their marital relationship. *Bipolar Disorders*, *18*(2), 192-199. doi:10.1111/bdi.12370

Grant, R., & Nash, M. (2017). Navigating unintelligibility: Queer Australian young women's negotiations of safe sex and risk. *Journal of Health Psychology, 23*(2), 306-319. doi:10.1177/1359105317741658

Graugaard, C. (2017). Sexuality as a health-promoting factor: Theoretical and clinical considerations. *Nature Reviews Urology*, 14(10), 577-578. doi:10.1038/nrurol.2017.117

Guilfoyle, M. (2003). Dialogue and Power: A critical analysis of power in dialogical therapy. *Family Process, 42*(3), 331-343. doi:10.1111/j.1545-5300.2003.00331.x

Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative Inquiry, 10*(2), 261-280. doi:10.1177/1077800403262360

Hafferty, F. W. (2008). Professionalism and the Socialization of Medical Students. In R. L. Cruess, S. R. Cruess, & Y. Stienert (Eds.), *Teaching medical professionalism* (pp. 53-70). New York: Cambridge University Press.

Hales, H., Romilly, C., Davison, S., & Taylor, P. J. (2006). Sexual attitudes, experience and relationships amongst patients in a high security hospital. *Criminal Behaviour and Mental Health, 16*(4), 254-263. doi:10.1002/cbm.636

Happell, B., Gordon, S., Bocking, J., Ellis, P., Roper, C., Liggins, J., ... & Scholz, B. (2018). How did I not see that? Perspectives of nonconsumer mental health researchers on the benefits of collaborative research with consumers. *International Journal of Mental Health Nursing*, *27*(4), 1230-1239. doi:10.1111/inm.12453

Happell, B., Platania-Phung, C., Bocking, J., Scholz, B., Horgan, A., Manning, F., ... & Pullo, J. (2018). Nursing students' attitudes towards people diagnosed with mental illness and

mental health nursing: An international project from Europe and Australia. *Issues in Mental Health Nursing, 39*(10), 829-839. doi:10.1080/01612840.2018.1489921

Hatala, A. R. (2012). The status of the "biopsychosocial" model in health psychology: Towards an integrated approach and a critique of cultural conceptions. *Open Journal of Medical Psychology, 1,* 51-62. doi:10.4236/ojmp.2012.14009

Hauck, Y., Nguyen, T., Frayne, J., Garefalakis, M., & Rock, D. (2015). Sexual and reproductive health trends among women with enduring mental illness: A survey of Western Australian community mental health services. *Health Care for Women International, 36*(4), 499-510. doi:10.1080/07399332.2014.973957

Heath, H., & White, I. (2002). *The challenge of sexuality in health care*. Oxford: Blackwell Science.

Hendry, A., Snowden, A., & Brown, M. (2018). When holistic care is not holistic enough: The role of sexual health in mental health settings. *Journal of Clinical Nursing, 27*(5-6), 1015-1027. doi:10.1111/jocn.14085

Higgins, A. (2007a). Impact of psychotropic medication on sexuality: Literature review. *British Journal of Nursing, 16*(9), 545-550. doi:10.12968/bjon.2007.16.9.23433.

Higgins, A. (2007b). *Veiling sexualities in a psychiatric nursing context: A grounded theory study* (Doctoral thesis, Trinity College, Dublin). Retrieved from http://www.tara.tcd.ie/handle/2262/77029

Higgins, A. (2009). Sexuality and gender. In P. J. Barker (Ed.), *Psychiatric and mental health nursing: The craft of caring* (2nd ed., pp. 618-625). London: Hodder Arnold.

Higgins, A., Barker, P., & Begley, C. M. (2006a). Iatrogenic sexual dysfunction and the protective withholding of information: In whose best interest?. *Journal of Psychiatric and Mental Health Nursing*, *13*(4), 437-446.

Higgins, A., Barker, P., & Begley, C. M. (2006b). Sexual health education for people with mental health problems: What can we learn from the literature? *Journal of Psychiatric and Mental Health Nursing*, *13*(6), 687-697. doi:10.1111/j.1365-2850.2006.01016.x

Higgins, A., Barker, P., & Begley, C. M. (2006c). Sexuality: The challenge to espoused holistic care. *International Journal of Nursing Practice*, 12(6), 345-351. doi:10.1111/j.1440-172X.2006.00593.x

Higgins, A., Barker, P., & Begley, C. M. (2008). 'Veiling sexualities': a grounded theory of mental health nurses' responses to issues of sexuality. *Journal of Advanced Nursing, 62*(3), 307-317. doi:10.1111/j.1365-2648.2007.04586.x

Higgins, A., Barker, P., & Begley, C. M. (2009). Sexuality and mental health nursing in Ireland: Weaving the veil of socialised inhibition. *Nurse Education Today*, *29*(3), 357-364. doi:10.1016/j.nedt.2008.07.003

Hollway, W. (1984). Women's power in heterosexual sex. *Women's Studies International Forum*, 7(1), 63–68. doi:10.1016/0277-5395(84)90085-2

Hordern, A. (2008). Intimacy and sexuality after cancer: A critical review of the literature. *Cancer Nursing*, 31, 2, E9-E17. doi:10.1097/01.NCC.0000305695.12873.d5

Howard, L. M., Trevillion, K., Khalifeh, H., Woodall, A., Agnew-Davies, R., & Feder, G. (2010). Domestic violence and severe psychiatric disorders: prevalence and interventions. *Psychological Medicine*, *40*(6), 881-893. doi:10.1017/S0033291709991589

Hughes, E. (2016). The sexual health and relationship needs of people with severe mental illness. *Journal of Psychiatric and Mental Health Nursing*, *23*(5), 338-343. Retrieved from http://eprints.hud.ac.uk/id/eprint/29028/3/Hughes.pdf

Hughes, E., Bassi, S., Gilbody, S., Bland, M., & Martin, F. (2016). Prevalence of HIV, hepatitis B, and hepatitis C in people with severe mental illness: A systematic review and meta-analysis. *The Lancet Psychiatry*, *3*(1), 40-48. doi:10.1016/S2215-0366(15)00357-0

Hughes, E., Edmondson, A. J., Onyekwe, I., Quinn, C., & Nolan, F. (2018). Identifying and addressing sexual health in serious mental illness: Views of mental health staff working in two National Health Service organizations in England. *International Journal of Mental Health Nursing*. doi:10.1111/inm.12402

Hunt, X., Braathen, S. H., Swartz, L., Carew, M. T., & Rohleder, P. (2018). Intimacy, intercourse and adjustments: Experiences of sexual life of a group of people with physical disabilities in South Africa. *Journal of Health Psychology*, *23*(2), 289-305. doi:10.1177/1359105317741761

Irwin, R. (1997). Sexual health promotion and nursing. *Journal of Advanced Nursing*, *25*(1), 170-177. doi:10.1046/j.1365-2648.1997.1997025170.x

Jackson, A.Y., & Mazzei, L.A. (2012). *Thinking with theory in qualitative research: Viewing data across multiple perspectives*. New York: Routledge.

Jagose, A. (1996). *Queer theory: An introduction*. NYU Press.

Johnson, K. (2015). Gender and sexuality issues in health psychology: Challenges from feminist and LGBTQ perspectives. In Murray, M. (ed), *Critical health Psychology* (2nd ed., pp. 108-124). New York: Palgrave Macmillion.

Johnson, M., & Bennett, E. (2015). *Everyday sexism: Australian women's experiences of street harassment*. Melbourne: The Australia Institute. Retrieved from https://www.tai.org.au/content/everyday-sexism

Jones, A. (2019). Sex is not a problem: The erasure of pleasure in sexual science research. *Sexualities, 22*(4), 643-668. doi:10.1177/1363460718760210

Katz, A. (2005a). Do ask, do tell: Why do so many nurses avoid the topic of sexuality? *American Journal of Nursing, 105*(7), 66-68. Retrieved from https://journals.lww.com/ajnonline/Fulltext/2005/07000/Do_Ask,_Do_Tell__Why_do_so_many_nurses_avoid_the.33.aspx

Katz, A. (2005b). The sounds of silence: Sexuality information for cancer patients. *Journal of Clinical Oncology, 23*(1), 238-241. doi:10.1200/JCO.2005.05.101

Kautz, D. D., Dickey, C. A., & Stevens, M. N. (1990). Using research to identify why nurses do not meet established sexuality nursing care standards. *Journal of Nursing Quality Assurance, 4*(3), 69-78. Retrieved from http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.457.1745&rep=rep1&type=pdf

Kidd, S. A., Veltman, A., Gately, C., Chan, K. J., & Cohen, J. N. (2011). Lesbian, gay, and transgender persons with severe mental illness: Negotiating wellness in the context of multiple sources of stigma. *American Journal of Psychiatric Rehabilitation, 14*(1), 13-39. doi:10.1080/15487768.2011.546277

Kitzinger, C. (2005). "Speaking as a heterosexual": (How) does sexuality matter for talk-in-Interaction? *Research on Language and Social Interaction,* 38(3), 221-265. doi:10.1207/s15327973rlsi3803_2

Kleinman, A. (1980). *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry* (Vol. 3). University of California Press.

Kneale, D., French, R., Spandler, H., Young, I., Purcell, C., Boden, Z., ... & Eastham, R. (2019). Conducting sexualities research: An outline of emergent issues and case studies from ten Wellcome-funded projects. *Wellcome Open Research*, *4*(137), 137. doi:10.12688/wellcomeopenres.15283.1.

Kulkin, H. S., Williams, J., Borne, H. F., de la Bretonne, D., & Laurendine, J. (2007). A review of research on violence in same-gender couples. *Journal of Homosexuality, 53*(4), 71-87. doi:10.1080/00918360802101385

La Pastina, A. C. (2006). The implications of an ethnographer's sexuality. *Qualitative Inquiry*, *12*(4), 724-735. doi:10.1177/1077800406288615

Leamy, M., Bird, V., Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. *British Journal of Psychiatry, 199*(6), 445-452. doi:10.1192/bjp.bp.110.083733

Lee, C. (2006). Critical health psychology: Who benefits?. *Journal of Health Psychology, 11*(3), 355-359. doi:10.1177/1359105306063303

Levine, S. B., & Scott, D. L. (2010). Sexual education for psychiatric residents. *Academic Psychiatry, 34*(5), 349-352. doi:10.1176/appi.ap.34.5.349

Levy, D. L. (2013). On the outside looking in? The experience of being a straight, cisgender qualitative researcher. *Journal of Gay & Lesbian Social Services, 25*(2), 197-209. doi:10.1080/10538720.2013.782833

Levy, R. A. (2014). A state of exception: Intersectionality, health, and social exemption. In D. Peterson, & V. R. Panfil (Eds.), *Handbook of LGBT communities, crime, and justice* (pp. 503-528). New York, NY: Springer.

Lewis, J., & Scott, E. (1997). The sexual education needs of those disabled by mental illness. *Psychiatric Rehabilitation Journal, 21*(2), 164. doi:10.1037/h0095323

Limerick, B., Burgess-Limerick, T., & Grace, M. (1996). The politics of interviewing: power relations and accepting the gift. *International Journal of Qualitative Studies in Education, 9*(4), 449-460. doi:10.1080/0951839960090406

Loeser, C., Pini, B., & Crowley, V. (2017). Disability and sexuality: Desires and pleasures. *Sexualities, 21*(3), 255-270. doi:10.1177/1363460716688682

Love, M., & Farber, B. A. (2017). Let's not talk about sex. *Journal of Clinical Psychology, 73*(11), 1489-1498. doi:10.1002/jclp.22530

Lupton, D. (1997). Foucault and the medicalisation critique. In A. R. Petersen, & R. Bunton (Eds.), *Foucault, health and medicine* (pp. 94-112). Psychology Press.

Lupton, D. (2012). *Medicine as culture: Illness, disease and the body* (3rd ed.). SAGE.

Lyons, A. C., & Chamberlain, K. (2006). *Health psychology: A critical introduction*. Cambridge University Press.

Lyons, A. C., & Chamberlain, K. (2017). Critical health psychology. In B. Gough (Ed.), *The Palgrave handbook of critical social psychology* (pp. 533-555). London: Palgrave Macmillan.

Macleod, C. I., Marx, J., Mnyaka, P., & Treharne, G. J. (2018). Ethics in critical research: Stories from the field. In C. I. Macleod, J. Marx, P. Mnyaka, & G. T. Treharne (Eds.). *The Palgrave handbook of ethics in critical research* (pp. 1-13). Cham: Palgrave Macmillan.

Manderson, L., Bennett, E., & Andajani-Sutjahjo, S. (2006). The social dynamics of the interview: Age, class, and gender. *Qualitative Health Research, 16*(10), 1317-1334. doi:10.1177/1049732306294512

Marecack, J., & Hare-Mustin, R.T. (2009). Clinical psychology: The politics of madness. In D. Fox, I. Prilleltensky, & S. Austin (Eds.), *Critical psychology: An introduction* (2nd ed., pp. 75-92). London: SAGE.

Marks, D. F. (2002). Freedom, responsibility and power: Contrasting approaches to health psychology. *Journal of Health Psychology, 7*(1), 5-19. doi:10.1177/1359105302007001062

Marks, D. F., Murray, M., Evans, B., & Willig, C. (2000). Sexual behaviour and experience. In D. F. Marks, M. Murray, B. Evans, C. Willig, C. M. Sykes, & C. Woodall (eds.), *Health psychology: Theory, research and practice* (pp. 203-226). SAGE.

Marx, J., & Treharne, G. J. (2018). Introduction: Researching 'Down','Up', and 'Alongside'. In C. I. Macleod, J. Marx, P. Mnyaka, & G. J. Treharne, G. J. (Eds.), *The Palgrave handbook of ethics in critical research* (pp. 327-338). Cham: Palgrave Macmillan.

Maylea, C. (2019). The capacity to consent to sex in mental health inpatient units. *Australian & New Zealand Journal of Psychiatry, 53*(11). doi:10.1177/0004867419850320

McAllister-Williams, R. H., Baldwin, D. S., Cantwell, R., Easter, A., Gilvarry, E., Glover, V., ... & Khalifeh, H. (2017). British Association for Psychopharmacology consensus

guidance on the use of psychotropic medication preconception, in pregnancy and postpartum 2017. *Journal of Psychopharmacology*, *31*(5), 519-552. doi:10.1177/0269881117699361

McCabe, J., & Holmes, D. (2014). Nursing, sexual health and youth with disabilities: A critical ethnography. *Journal of Advanced Nursing*, *70*(1), 77-86. doi:10.1111/jan.12167

McCann, E. (2000). The expression of sexuality in people with psychosis: breaking the taboos. *Journal of Advanced Nursing*, 32(1), 132-138. doi:10.1046/j.1365-2648.2000.01452.x

McCann, E. (2003). Exploring sexual and relationship possibilities for people with psychosis – a review of the literature. *Journal of Psychiatric and Mental Health Nursing*, *10*, 640–649. doi:10.1046/j.1365-2850.2003.00635.x

McCann, E. (2010). Investigating mental health service user views regarding sexual and relationship issues. *Journal of Psychiatric and Mental Health Nursing*, *17*(3), 251-259. doi:10.1111/j.1365-2850.2009.01509.x

McCann, E., Donohue, G., de Jager, J., Nugter, A., Stewart, J., Eustace-Cook, J. (2019). Sexuality and intimacy among people with serious mental illness: A systematic review of qualitative research. *JBI Database of Systematic Reviews and Implementation Reports*, *17*(1): 74-125. doi:10.11124/JBISRIR-2017-003824

McDonald, J. (2013). Coming out in the field: A queer reflexive account of shifting researcher identity. *Management Learning*, *44*(2), 127-143. doi:10.1177/1350507612473711

McDonald, J. (2015). Expanding queer reflexivity: The closet as a guiding metaphor for reflexive practice. *Management Learning, 47*(4), 391-406. doi:10.1177/1350507615610029

McFarland, S. A. (2015). Power. In J. D. Wright (Ed.), *International encyclopedia of the social & behavioral sciences* (2nd ed., pp. 760-764). Elsevier. doi:10.1016/B978-0-08-097086-8.93104-0

McMillan, E., Adan Sanchez, A., Bhaduri, A., Pehlivan, N., Monson, K., Badcock, P., . . . O'Donoghue, B. (2017). Sexual functioning and experiences in young people affected by mental health disorders. *Psychiatry Research, 253,* 249-255. doi:10.1016/j.psychres.2017.04.009

McPhillips, K., Braun, V., & Gavey, N. (2001, March). Defining (hetero) sex: how imperative is the "coital imperative"?. In *Women's Studies International Forum* (Vol. 24, No. 2, pp. 229-240). Pergamon.

Mick, J., Hughes, M., & Cohen, M. (2004). Using the BETTER model to assess sexuality. *Clinical Journal of Oncology Nursing, 8*(1), 84–86. doi:10.1188/04.CJON.84-86

Miller, S. A., & Byers, E. S. (2012). Practicing psychologists' sexual intervention self-efficacy and willingness to treat sexual issues. *Archives of Sexual Behavior, 41*(4), 1041-1050. doi:10.1007/s10508-011-9877-3

Montejo, A. L. (2019). Sexuality and mental health: The need for mutual development and research. *Journal of Clinical Medicine, 8 (11),* 1794. doi:10.3390/jcm8111794

Montejo, A. L., Montejo, L., & Baldwin, D. S. (2018). The impact of severe mental disorders and psychotropic medications on sexual health and its implications for clinical management. *World Psychiatry, 17*(1), 3-11. doi:10.1002/wps.20509

Morgan, E. M., & Davis-Delano, L. R. (2016). Heterosexual marking and binary cultural conceptions of sexual orientation. *Journal of Bisexuality, 16*(2), 125-143. doi:10.1080/15299716.2015.1113906

Nettleton, S. (1997). Governing the risky self: how to become healthy, wealthy and wise. In A. R. Petersen & R. Bunton (Eds.), *Foucault, health and medicine* (pp. 207-222). Psychology Press.

Nnaji, R. N., & Friedman, T. (2008). Sexual dysfunction and schizophrenia: Psychiatrists' attitudes and training needs. *Psychiatric Bulletin, 32*(6), 208-210. doi:10.1192/pb.bp.107.016162

NSW Ministry of Health. (2013). *Sexual safety of mental health consumers guidelines*. Sydney, Australia. Retrieved from https://www.mentalhealthcarersnsw.org/wp-content/uploads/2017/07/GL2013_012Sexual-Safety-of-Mental-Health-Consumers-Guidelines.pdf

Oakley, A. (2016). Interviewing women again: Power, time and the gift. *Sociology, 50*(1), 195-213. doi:10.1177/0038038515580253

Odey, K. (2009). Legitimizing patient sexuality and sexual health to provide holistic care. *Gastrointestinal Nursing, 7,* 43-47. doi:10.12968/gasn.2009.7.8.44749

Östman, M. (2014). Low satisfaction with sex life among people with severe mental illness living in a community. *Psychiatry Research, 216*(3), 340-345. doi:10.1016/j.psychres.2014.02.009

Our Consumer Place (2010). *So you have a 'Mental illness'... What now?*. Victoria, Australia. Retrieved from https://www.ourcommunity.com.au/files/OCP/MentalIllnessBook.pdf

Pacitti, R., & Thornicroft, G. (2009). Sex, relationships and mental health. *A Life in the Day, 13*, 27-30. doi:10.1108/13666282200900008

Pandor, A., Kaltenthaler, E., Higgins, A., Lorimer, K., Smith, S., Wylie, K., & Wong, R. (2015). Sexual health risk reduction interventions for people with severe mental illness: A systematic review. *BMC Public Health, 15*. doi:10.1186/s12889-015-1448-4

Peel, E. (2001). Mundane heterosexism: Understanding incidents of the everyday. *Women's Studies International Forum, 24*(5), 541-554. doi:10.1016/S0277-5395(01)00194-7

Perales, F., Lersch, P. M., & Baxter, J. (2017). *Birth cohort, ageing and gender ideology: Lessons from British and Australian panel data*. Institute for Social Science Research, The University of Queensland. Retrieved from www.lifecoursecentre.org.au/wp-content/uploads/2018/06/2017-01-LCC-Working-Paper-Perales-et-al..pdf

Perry, B. L., & Wright, E. R. (2006). The sexual partnerships of people with serious mental illness. *Journal of Sex Research, 43*(2), 174-181. doi:10.1080/00224490609552312

Perry, B. L., Freieh, E., & Wright, E. R. (2018). Therapeutic social control of people with serious mental illness: An empirical verification and extension of theory. *Society and Mental Health, 8*(20), 108-122. doi:10.1177/2156869317725891

Pini, B. (2005). Interviewing men: Gender and the collection and interpretation of qualitative data. *Journal of Sociology, 41*, 201–216. doi:10.1177/1440783305053238

Priebe, S. (2016). A social paradigm in psychiatry – themes and perspectives. *Epidemiology and Psychiatric Sciences, 25*(6), 521-527. doi:10.1017/S2045796016000147

Prilleltensky, I., & Prilleltensky, O. (2003). Towards a critical health psychology practice. *Journal of Health Psychology, 8*(2), 197-210. doi:10.1177/1359105303008002659

QSR International. (2018). *N*vivo 12* [computer software] (2018 ed.). Doncaster, Australia: QSR International.

Quinn, C. (2013). *The practice of mental health nurses: The need to include sexuality in consumer care*. (Doctoral thesis, Central Queensland University: Higher Education Division.)

Quinn, C., & Browne, G. (2009). Sexuality of people living with a mental illness: a collaborative challenge for mental health nurses. *International Journal of Mental Health Nursing, 18*(3), 195-203. doi:10.1111/j.1447-0349.2009.00598.x

Quinn, C., & Happell, B. (2012). Getting BETTER: Breaking the ice and warming to the inclusion of sexuality in mental health nursing care. *International Journal of Mental Health Nursing, 21*(2), 154-162. doi:10.1111/j.1447-0349.2011.00783.x

Quinn, C., & Happell, B. (2015a). Consumer sexual relationships in a Forensic mental health hospital: Perceptions of nurses and consumers. *International Journal of Mental Health Nursing, 24*(2), 121-129.

Quinn, C., & Happell, B. (2015b). Exploring sexual risks in a forensic mental health hospital: Perspectives from patients and nurses. *Issues in Mental Health Nursing, 36*(9), 669-677.

Quinn, C., & Happell, B. (2015c). Sex on show. Issues of privacy and dignity in a Forensic mental health hospital: Nurse and patient views. *Journal of Clinical Nursing, 24*(15-16), 2268-2276.

Quinn, C., & Happell, B. (2016). Supporting the sexual intimacy needs of patients in a longer stay inpatient forensic setting. *Perspectives in Psychiatric Care, 52*(4), 239-247.

Quinn, C., Happell, B., & Browne, G. (2011a). Sexuality and consumers of mental health services: The impact of gender and boundary issues. *Issues in Mental Health Nursing, 32*(3), 170-176. doi:10.3109/01612840.2010.531518

Quinn, C., Happell, B., & Browne, G. (2011b). Talking or avoiding? Mental health nurses' views about discussing sexual health with consumers. *International Journal of Mental Health Nursing, 20*, 21-28. doi:10.1111/j.1447-0349.2010.00705.x

Quinn, C., Happell, B., & Browne, G. (2012). Opportunity lost? Psychiatric medications and problems with sexual function: a role for nurses in mental health. *Journal of Clinical Nursing, 21*(3-4), 415-423. doi:10.1111/j.1365-2702.2011.03908.x

Quinn, C., Happell, B., & Welch, A. (2013a). Talking about sex as part of our role: Making and sustaining practice change. *International Journal of Mental Health Nursing, 22*(3), 231-240. doi:10.1111/j.1447-0349.2012.00865.x

Quinn, C., Happell, B., & Welch, A. (2013b). The 5-As framework for including sexual concerns in mental health nursing practice. *Issues in Mental Health Nursing*, 34(1), 17-24. doi:10.3109/01612840.2012.711433

Quinn, C., Platania-Phung, C., Bale, C., Happell, B., & Hughes, E. (2018). Understanding the current sexual health service provision for mental health consumers by nurses in mental

health settings: Findings from a Survey in Australia and England. *International Journal of Mental Health Nursing, 27*(5), 1522-1534. doi:10.1111/inm.12452

Ravenhill, J. P., Poole, J., Brown, S. D., & Reavey, P. (2020). Sexuality, risk, and organisational misbehaviour in a secure mental healthcare facility in England. *Culture, Health & Sexuality*, 1-16. doi:10.1080/13691058.2019.1683900

Reissing, E. D., & Di Giulio, G. (2010). Practicing clinical psychologists' provision of sexual health care services. *Professional Psychology: Research and Practice, 41*(1), 57–63. doi:10.1037/a0017023

Rele, K., & Wylie, K. (2007). Management of psychosexual and relationship problems in general mental health services by psychiatry trainees. *International Journal of Clinical Practice, 61*(10), 1701-1704. doi:10.1111/j.1742-1241.2007.01455.x

Riggs, D. W. (2011). Queering evidence-based practice. *Psychology & Sexuality, 2*(1), 87-98. doi:10.1080/19419899.2011.536319

Riggs, D. W., & Treharne, G. J. (2017). Queer theory. In B. Gough (Ed.), *The Palgrave handbook of critical social psychology* (pp. 101-121). London: Palgrave Macmillan.

Rohleder, P., & Flowers, P. (2018). Towards a psychology of sexual health. *Journal of Health Psychology, 23*(2), 143-147. doi:10.1177/1359105317750162

Rooke, A. (2012). Queer in the field: On emotions, temporality, and performativity in ethnography. In K. Browne & C. J. Nash (Eds.), *Queer methods and methodologies: Intersecting queer theories and social science research* (pp. 25-40). New York: Routledge.

Rubin, G. (1984). Thinking sex: Notes for a radical theory of the politics of sexuality. In C. S. Vance (Ed.), *Pleasure and danger: Exploring female sexuality* (pp. 267-317). Boston: Routledge.

Salkeld, J. (2015). Assessing sexual health in mental health service users. *Nursing Standard*, *30*(5), 53. doi:10.7748/ns.30.5.53.e10082

Sandfort, T. G. M., & Ehrhardt, A. A. (2004). Sexual health: A useful public health paradigm or a moral imperative? *Archives of Sexual Behavior, 33*(3), 181-187. doi:10.1023/B:ASEB.0000026618.16408.e0

Schirmann, F. (2013). Badness, madness and the brain: The late 19th-century controversy on immoral persons and their malfunctioning brains. *History of the Human Sciences, 26*(2), 33-50. doi:10.1177/0952695113482317

Scholz, B., Bocking, J., Hedt, P., Lu, V. N., & Happell, B. (2019a). 'Not in the room, but the doctors were': An Australian story-completion study about consumer representation. *Health Promotion International*. doi:10.1093/heapro/daz07

Scholz, B., Gordon, S., Bocking, J., Liggins, J., Ellis, P., Roper, C., . . . Happell, B. (2019b). "There's just no flexibility": How space and time impact mental health consumer research. *International Journal of Mental Health Nursing, 28*(4), 899-908. doi:10.1111/inm.12589

Scholz, B., Roper, C., Juntanamalaga, P., & Happell, B. (2019c). Understanding the role of allies in systemic consumer empowerment: A literature review. *Issues in Mental Health Nursing*, *40*(4), 354-361. doi:10.1080/01612840.2018.1553004

Scott, A., & Wilson, L. (2011). Valued identities and deficit identities: Wellness Recovery Action Planning and self-management in mental health. *Nursing Inquiry*, *18*(1), 40-49. doi:10.1111/j.1440-1800.2011.00529.x

Semp, D., & Read, J. (2015). Queer conversations: Improving access to, and quality of, mental health services for same-sex-attracted clients. *Psychology & Sexuality*, *6*(3), 217-228. doi:10.1080/19419899.2014.890122

Shildrick, M. (2007). Contested pleasures: The sociopolitical economy of disability and sexuality. *Sexuality Research & Social Policy*, *4*(1), 53. doi:10.1525/srsp.2007.4.1.53

Shildrick, M. (2009). *Dangerous discourses of disability, subjectivity and sexuality*. Springer.

Slade, M., Amering, M., Farkas, M., Hamilton, B., O'Hagan, M., Panther, G., . . . Whitley, R. (2014). Uses and abuses of recovery: Implementing recovery-oriented practices in mental health systems. *World Psychiatry*, *13*(1), 12-20. doi:10.1002/wps.20084

Southall, D. (2017). *Clinical psychologists' views about talking to people with psychosis about sexuality and intimacy: A Q-methodological study* (Doctoral thesis, Staffordshire University & Keele University, United Kingdom). Retrieved from http://eprints.staffs.ac.uk/4439/1/DSOUTHALL%20THESIS%20PDF.pdf

Sreedaran, P. (2019). Documentation of Sexual History by Psychiatry Postgraduate Trainees: Lessons to Be Learnt. *Journal of Psychosexual Health*, *1*(1), 84-86. doi:10.1177/2631831818823634

Stelzl, M., Stairs, B., & Anstey, H. (2018). A narrow view: The conceptualization of sexual problems in human sexuality textbooks. *Journal of Health Psychology*, *23*(2), 148-160.

Stevenson, R. W. (2004). Sexual medicine: Why psychiatrists must talk to their patients about sex. *The Canadian Journal of Psychiatry, 49*(10), 673-677. doi:10.1177/070674370404901004

Stewart, E. (2018). Subjects and Objects: An Ethic of Representing the Other. In C. I. Macleod, J. Marx, P. Mnyaka, & G. J. Treharne, G. J. (Eds.), *The Palgrave handbook of ethics in critical research* (pp. 415-427). Cham: Palgrave Macmillan.

Sullivan, N. (2003). *A critical introduction to queer theory*. NYU Press.

Suls, J., & Rothman, A. (2004). Evolution of the Biopsychosocial Model: Prospects and Challenges for Health Psychology. *Health Psychology, 23*(2), 119–125. doi:10.1037/0278-6133.23.2.119

Taylor, B., & Davis, S. (2006). Using the extended PLISSIT model to address sexual healthcare needs. *Nursing Standard, 21*(11), 35-41. Retrieved from http://proxy.library.adelaide.edu.au/login?url=https://search-proquest-com.proxy.library.adelaide.edu.au/docview/219837713?accountid=8203

Tennille, J. & Bohrman, C. (2017). *Conversations about Intimacy and Sexuality: A Training Toolkit Using Motivational Interviewing*. Philadelphia, PA: Temple University Collaborative on Community Inclusion for Individuals with Psychiatric Disabilities. Retrieved from http://www.tucollaborative.org/sdm_downloads/sexuality-and-intimacy-toolkit/

Tennille, J., & Wright, E. (2013). Addressing the intimacy interests of people with mental health conditions: Acknowledging consumer desires, provider discomforts, and system denial. *Temple University collaborative on community inclusion of individuals with*

psychiatric disability. Retrieved from http://tucollaborative.org/wp-content/uploads/2017/04/Addressing-the-Intimacy-Interests-of-Persons-with-Mental-Health-Conditions.pdf

Tennille, J., Solomon, P., & Bohrman, C. (2014). Using the FIELD model to prepare social work students and field instructors on sexuality and intimacy for persons with psychiatric disabilities. *Sexuality and Disability*, 32(4), 469-483. doi:10.1007/s11195-014-9380-6

Teo, T. (2009). Philosophical concerns in critical psychology. In D. Fox, I. Prilleltensky, & S. Austin (Eds.), *Critical psychology: An introduction* (2nd ed., pp. 36-54). London: SAGE.

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. In C. Willig & W. S. Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (2nd ed., pp. 17-37). London: SAGE.

The Royal Australian and New Zealand College of Psychiatrists (2016). *Recovery and the psychiatrist: Position statement 86*. Retrieved from https://www.ranzcp.org/news-policy/policy-and-advocacy/position-statements/recovery-and-the-psychiatrist

The Royal Australian and New Zealand College of Psychiatrists (2017). *Fact sheet: What's a psychiatrist?* Retrieved from https://www.yourhealthinmind.org/psychiatry-explained/whats-a-psychiatrist

Thompson, J. D. (2019). Predatory schools and student non-lives: A discourse analysis of the Safe Schools Coalition Australia controversy. *Sex Education, 19*(1), 41-53. doi:10.1080/14681811.2018.1475284

Thomson, M. (2010). Disability, psychiatry, and eugenics. In A. Bashford & P. Levine (Eds.), *The Oxford handbook of the history of eugenics* (pp. 116-133). USA: Oxford University Press.

Thornicroft, G., Rose, D., & Kassam, A. (2007). Discrimination in health care against people with mental illness. *International Review of Psychiatry, 19*(2), 113-122. doi:10.1080/09540260701278937

Tiefer, L. (2006). Female sexual dysfunction: A case study of disease mongering and activist resistance. *PLoS Medicine, 3*(4), e178. doi:10.1371/journal.pmed.0030178

Tolman, D. L., & Diamond, L. M. (2014). Sexuality theory: A review, a revision, and a recomendation. In D. L. Tolman, L. M. Diamond, J. A. Bauermeister, W. H. George, J. G. Pfaus, & L. M. Ward (Eds.), *APA handbook of sexuality and psychology: Vol. 1: Person-based approaches* (pp. 3-27). Washington, DC, USA: American Psychological Association.

Tracy, S. J. (2010). Qualitative quality: Eight "Big-Tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851. doi:10.1177/1077800410383121

Treharne, G. J., & Riggs, D. W. (2015). Ensuring quality in qualitative research. In P. Rohleder & A. C. Lyons (Eds.), *Qualitative research in clinical and health psychology* (pp. 57-73). Basingstoke: Palgrave MacMillan.

Urry, K., & Pearce, S. (2019). Queer. *Writing From Below, 4*(3). Retrieved from https://writingfrombelow.org/space-and-place/queer/

Ussher, J. M., & Walkerdine, V. (2001). Guest editorial: Critical psychology. *Australian Psychologist, 36*. 1-3. Retrieved from https://www.tandfonline.com/doi/pdf/10.1080/00050060108259624

Ussher, J. M., Perz, J., Gilbert, E., Wong, W. T., Mason, C., Hobbs, K., & Kirsten, L. (2013). Talking about sex after cancer: A discourse analytic study of health care professional accounts of sexual communication with patients. *Psychology & Health, 28*(12), 1370-1390. doi:10.1080/08870446.2013.811242

Vähäsantanen, K., & Saarinen, J. (2012). The power dance in the research interview: Manifesting power and powerlessness. *Qualitative Research, 13*(5), 493-510. doi:10.1177/1468794112451036

Vines, R. (2011). Equity in health and wellbeing: Why does regional, rural and remote Australia matter? *InPsych: The Bulletin of the Australian Psychological Society Ltd, 33*. Retrieved from: http://www.psychology.org.au/Content.aspx?ID=3960

Volman, L., & Landeen, J. (2007). Uncovering the sexual self in people with schizophrenia. *Journal of Psychiatric & Mental Health Nursing, 14*, 411-417. doi:10.1111/j.1365-2850.2007.01099.x

Wagle, T., & Cantaffa, D. T. (2008). Working our hyphens exploring identity relations in qualitative research. *Qualitative Inquiry, 14*(1), 135-159. doi:10.1177/1077800407309328

Wainberg, M. L., Cournos, F., Wall, M. M., Norcini Pala, A., Mann, C. G., Pinto, D., . . . McKinnon, K. (2016). Mental illness sexual stigma: Implications for health and recovery. *Psychiatric Rehabilitation Journal*, 39(2), 90-96. doi:10.1037/prj0000168

Warner, J., Pitts, N., Crawford, M. J., Serfaty, M., Prabhakaran, P., & Amin, R. (2004). Sexual activity among patients in psychiatric hospital wards. *Journal of the Royal Society of Medicine*, *97*(10), 477-479. doi:10.1177/0141076809701005

Weedon, C. (1997). *Feminist practice & poststructuralist theory* (2nd ed.). UK: Blackwell Publishers.

Weeks, J. (2010). *Sexuality* (3rd ed.). Milton Park, Abingdon, Oxon: Routledge.

West, L. M., Stepleman, L. M., Wilson, C. K., Campbell, J., Villarosa , M., Bodie, B., & Decker, M. (2012). It's supposed to be personal: Personal and educational factors associated with sexual health attitudes, knowledge, comfort and skill in health profession students. *American Journal of Sexuality Education*, *7*(4), 329-354. doi:10.1080/15546128.2012.740945

Wetherell, M. (1998). Positioning and interpretative repertoires: Conversation analysis and post-structuralism in dialogue. *Discourse & Society*, *9*(3), 387-412. doi:10.1177/0957926598009003005

White, R., Haddock, G., & Varese, F. (2019). Supporting the intimate relationship needs of service users with psychosis: what are the barriers and facilitators?. *Journal of Mental Health*, 1-7. doi:10.1080/09638237.2019.1608928

Wigginton, B., & Setchell, J. (2016). Researching stigma as an outsider: Considerations for qualitative outsider research. *Qualitative Research in Psychology*, 13(3), 246-263. doi:10.1080/14780887.2016.1183065

Wigginton, B., Gibson, A., & Scholz, B. (Producers). (2018, August 31). *The operative word, volume 1 issue 2: Transparency* [Audio podcast]. Retrieved from https://anchor.fm/theoperativeword/episodes/Volume-1-Issue-2-Transparency-e24ed8

Wilkinson, S. (1988). The role of reflexivity in feminist psychology. *Women's Studies International Forum*, 11(5), 493-502. doi:10.1016/0277-5395(88)90024-6

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). UK: McGraw-hill education.

Willig, C. (2015). Discourse analysis and health psychology. In M. Murray (Ed.), *Critical health psychology* (2ne ed., pp. 200-216). Palgrave Macmillan.

Willig, C. (2016). Constructivism and 'The Real World': Can they co-exist?. *QMiP Bulletin*, (21). Retrieved from https://openaccess.city.ac.uk/id/eprint/13576/1/

Willig, C. (2017). Interpretation in qualitative research. In C. Willig & W. S. Rogers (Eds.), *The SAGE handbook of qualitative research in psychology* (2nd ed., pp. 274-288). London: SAGE.

World Health Organization. (2006). *Defining sexual health: Report of a technical consultation on sexual health*, 28-31 January 2002, Geneva, Switzerland: WHO. Retrieved from https://www.who.int/reproductivehealth/publications/sexual_health/defining_sh/en/

World Health Organization. (2010). *Measuring sexual health: conceptual and practical considerations and related indicators*. Geneva, Switzerland: WHO. Retrieved from https://www.who.int/reproductivehealth/publications/monitoring/who_rhr_10.12/en/

World Health Organization. (2015). *Brief sexuality-related communication: Recommendations for a public health approach*. Geneva, Switzerland: WHO. Retrieved

from https://www.who.int/reproductivehealth/publications/sexual_health/sexuality-related-communication/en/

Wright, E. R., McCabe, H. A., & Koorman, H. E. (2012). Institutional capacity to respond to the ethical challenges of patient sexual expression in state psychiatric hospitals in the United States. *Journal of Ethics in Mental Health, 7*, 1-5. Retrieved from https://scholarworks.gsu.edu/sociology_facpub/5/

Wright, E. R., Wright, D. E., Perry, B. L., & Foote-Ardah, C. E. (2007). Stigma and the sexual isolation of people with serious mental illness. *Social Problems, 54*(1), 78-98. doi:10.1525/sp.2007.54.1.78

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215-228. doi:10.1080/08870440008400302

Zatloff, J. P., Silke, A., Philip, Z., & Ward, M. C. (2020). Navigating a Complex Health System: The Perceptions of Psychiatric Residents in Addressing Sexual and Reproductive Health of Women with Severe Mental Illness. *Academic Psychiatry*, 1-5. doi:10.1007/s40596-020-01197-x